LOS ANGELES UNIFIED SCHOOL DISTRICT
Office of the Chief Medical Director
District Nursing Services

Parent Consent and Authorized Healthcare Provider Authorization for
DIABETES: TREATMENT OF HYPOGLYCEMIA at School and School-Sponsored Events

Student:	**DOB:**	**Date:**
School:	**PHONE:**	**FAX:**

NOTE: STANDARD PROCEDURE FOR DIABETES: TREATMENT OF HYPOGLYCEMIA IS ATTACHED.
PLEASE REVIEW AND CHECK APPROPRIATE BOX TO INDICATE AUTHORIZATION.

1. Check one:

☐ I have reviewed and approved the attached standardized procedure as written.

☐ I have reviewed and approved the attached standardized procedure as written with the attached modifications.

☐ I **do not** approve of LAUSD's standardized procedure. I have attached my alternative procedure and recommendations.

2. PRN (if needed) for ______________________________

3. Special Instructions: ______________________________

Authorized Healthcare Provider Authorization for DIABETES: TREATMENT OF HYPOGLYCEMIA in School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that initial emergency management services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide the written authorization. Authorizations may be faxed or e-mailed.

Authorized Healthcare Provider Name__________ **Signature**__________ **Date**__________

Phone__________ **Address**__________ **City**__________ **Zip** __________

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number**__________

Parent Consent for Authorization and Management of DIABETES: TREATMENT OF HYPOGLYCEMIA in School Setting

I (we) the undersigned, the parent/guardian(s) of the above-named student, request that the above standardized procedure, be administered to my (our) child in accordance with state laws and regulations. I (we) will:

1. provide the necessary supplies and equipment;
2. notify the school nurse if there is a change in child's health status, or attending healthcare provider;
3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization; and
4. provide new written consent/authorization yearly.

I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Parent(s)/Guardian(s) Print name__________ **Signature**__________ **Date** __________

Home phone:__________ **Work phone:**__________ **Cell Phone**__________

Licensed Nurse Acknowledgement of Complete and Accurate Order

__________	__________	__________	__________
Printed Name of Nurse	**Signature**	**Title (RN, LVN)**	**Date**

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☐ I **do not** approve of LAUSD's standardized procedure. I have attached my alternative procedure and recommendations.

4. PRN (if needed) for ____

5. Special Instructions: ____

Authorized Healthcare Provider Authorization for DIABETES: TREATMENT OF HYPOGLYCEMIA in School Setting

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Authorized Healthcare Provider Name__________________________ **Signature**____________________ **Date**______________

Phone______________________**Address**____________________________**City**____________________**Zip** __________________

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number**____

Consentimiento del padre de familia para autorizar el proceso de TRATAMIENTO DE LA HIPOGLUCEMIA en el entorno escolar

Yo, el abajo firmante, padre de familia/tutor (legal) del estudiante cuyo nombre aparece arriba, solicito que se aplique a mi hijo el procedimiento de atención médica especializada en conformidad con las leyes y reglamentos estatales. Me comprometo a:

1. Proporcionar los suministros y equipo necesario;
2. Avisarle a la enfermera escolar si hay un cambio en el estado de salud de mi hijo; o bien al proveedor de atención médica; y
3. Avisarle a la enfermera escolar inmediatamente y proporcionar una nueva autorización/consentimiento en caso de cualquier cambio en la autorización antes citada.
4. Anualmente proporcionar autorización/ consentimiento escrito.

Dar consentimiento a la enfermera escolar para comunicarse con el proveedor de servicios de salud cuando sea necesario.

Padre de familia/tutor (letra de molde):______________________**Firma:**________________________**Fecha:**________________

Teléfono del hogar:__________________**Tel. del trabajo:**______________________**Tel. del celular:** ________________________

Licensed Nurse Acknowledgement of Complete and Accurate Order

______________________________	______________________________	_______________	_______________
Printed Name of Nurse	**Signature**	**Title (RN, LVN)**	**Date**