

LOS ANGELES UNIFIED SCHOOL DISTRICT

Office of the Chief Medical Director

District Nursing Services

Parent Consent and Healthcare Provider Authorization for

GASTROSTOMY: TUBE REPLACEMENT at School and School-Sponsored Events

Student:	DOB:	Grade:
School:	Phone:	Fax:

PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.

NOTE: LAUSD SPECIALIZED PHYSICAL HEALTHCARE PROCEDURE FOR

GASTROSTOMY: TUBE REPLACEMENT IS ATTACHED.

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 the standardized procedure. I have attached my alternative procedure and recommendations.

2. Gastrostomy tube replacement is performed at school PRN (as needed) for _____

3. Special Instructions: _____

Authorized Healthcare Provider Authorization for GASTROSTOMY: TUBE REPLACEMENT 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 specialized physical healthcare procedures 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.

*Authorized Healthcare Provider Name _____ Signature _____ Date _____
 Phone _____ Address _____ City _____ Zip _____

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

Parent Consent for Authorization for GASTROSTOMY: TUBE REPLACEMENT in School Setting

I, the undersigned, the parent/guardian of the above-named student, request that the specialized physical healthcare procedure, Gastrostomy Tube Replacement, be administered to my child in accordance with state laws and regulations. I 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; and
3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.
4. provide new written consent/authorization yearly.

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

Parent/Guardian: (Print Name): _____ Signature: _____ Date _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

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

February 2023

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- I **do not** approve of the standardized procedure. I have attached my alternative procedure and recommendations.

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***Authorized Healthcare Provider Name** _____ **Signature** _____ **Date** _____

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

Consentimiento del padre de familia para autorizar el proceso de REEMPLAZO DE TUBO GASTROINTESTINAL 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, reemplazo de tubo gastrointestinal, 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 Completeness and Meets District Guidelines

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