

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

**Parent Consent and Authorized Healthcare Provider Authorization for
GASTROSTOMY FEEDING: BOLUS METHOD at School and School-Sponsored Events**

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

NOTE: STANDARD EMERGENCY CARE PROCEDURE FOR GASTROSTOMY FEEDING: BOLUS METHOD IS ATTACHED. PLEASE REVIEW AND SIGN FORM 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 the standardized procedure. I have attached my alternative procedure and recommendations.

2. Time/Frequency to be administered at school _____ and/or PRN if needed for _____

3. Special Instructions:

- Name of feeding: _____ Amount: _____
- Amount of water flush: _____
- Medication/s via Gastrostomy Tube: No Yes (medication authorization/s attached)
- Oral feedings: No Yes if yes, specify: _____

Authorized Healthcare Provider Authorization for GASTROSTOMY FEEDING: BOLUS METHOD 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 and Management of GASTROSTOMY FEEDING: BOLUS METHOD in School Setting

I, the undersigned, the parent/guardian of the above-named student, request that the specialized physical healthcare procedure 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

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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 que se autorice y aplique el proceso de
NUTRICIÓN GASTROINTESTINAL: MÉTODO DE BOLO 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 Completeness and Meets District Guidelines

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