May 2017

LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Health and Human Services
District Nursing Services

Parent Consent and Healthcare Provider Authorization for
JEJUNOSTOMY TUBE FEEDING: SLOW DRIP METHOD OR PUMP 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
Jejunostomy Tube Feeding: Slow Drip Method or Pump 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. Time/Frequency to be performed at school _____

3. Special Instructions:

Type of feeding device: ☐ Jejunostomy tube ☐ Gastrostomy/Jejunostomy tube
Name of Feeding:_____
☐ Continuous: Amount to be infused: _____at rate _____over_____# hours
☐ Intermittent: Amount to be infused: _____at rate _____over_____# hours
Flushing protocol: Tube is flushed ☐ before feeding ☐after feeding
☐every _____hours during feeding ☐whenever feeding is interrupted
Amount of water flush:_____
☐ Medication/s via tube: ☐ No ☐ Yes (medication/s authorization attached)
☐ via G/J tube into G-port ☐ via J-tube into jejunum
☐ Oral feedings: ☐ No ☐ Yes If yes, specify: _____

Authorized Healthcare Provider Authorization for Jejunostomy Tube Feeding: Slow Drip Method or Pump 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 Jejunostomy Tube Feeding: Slow Drip Method or Pump 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:** _____

Adapted from Form B, Section 3, *The Green Book: Guidelines for Specialized Physical Healthcare Physical Healthcare Procedures in School Settings (4/11)*

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

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☐ 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 performed at school _____

3. Special Instructions:

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☐ via G/J tube into G-port ☐ via J-tube into jejunum
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Authorized Healthcare Provider Authorization for Jejunostomy Tube Feeding: Slow Drip Method or Pump 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 que se autorice y aplique el proceso de
NUTRICIÓN POR MEDIO DE YEYUNOSTOMÍA: MÉTODO DE SONDAJE O BOMBEO 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:** _____