LOS ANGELES UNIFIED SCHOOL DISTRICT
Office of the Chief Medical Director
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____hour 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:_____

Licensed Nurse Acknowledgement of Complete and Accurate Order

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

LOS ANGELES UNIFIED SCHOOL DISTRICT
Office of the Chief Medical Director
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_____hour 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** _____

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:** _____

Licensed Nurse Acknowledgement of Complete and Accurate Order

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