May 2017

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

Parent Consent and Authorized Healthcare Provider Authorization for
OSTOMY CARE 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 OSTOMY CARE IS ATTACHED.

Please Specify type of ostomy _____

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: _____
_____

Authorized Healthcare Provider Authorization for OSTOMY CARE 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 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 OSTOMY CARE In School Setting

I, the undersigned, the parent/guardian(s) 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 (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,
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:** _____

May 2017

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

Parent Consent and Authorized Healthcare Provider Authorization for OSTOMY CARE 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 OSTOMY CARE IS ATTACHED.

Please Specify type of ostomy _____

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: _____
_____

Authorized Healthcare Provider Authorization for OSTOMY CARE 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 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 autorizar el proceso de CUIDADOS DE OSTONOMÍA 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
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:** _____