

LOS ANGELES UNIFIED SCHOOL DISTRICT

Office of the Chief Medical Director

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:** _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

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

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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: _____

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

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

Aug 2024