

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

**Parent Consent and Healthcare Provider Authorization for
DIAZEPAM RECTAL GEL (DIASTAT) ADMINISTRATION at School and School-Sponsored Events**

Student:	DOB:	Date:
School:	Phone:	Fax:

**PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION.
NOTE: LAUSD STANDARDIZED PROCEDURE FOR Diazepam Rectal Gel (Diastat) ADMINISTRATION 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 LAUSD's standardized procedure. I have attached my alternative procedure and recommendations.

2. PRN if needed for _____

3. Special Instructions: _____

Authorized Healthcare Provider Authorization for Diazepam Rectal Gel (Diastat) 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 for Diazepam Rectal Gel (Diastat) 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

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<p>PLEASE REVIEW AND CHECK THE APPROPRIATE BOX TO INDICATE AUTHORIZATION. NOTE: LAUSD STANDARDIZED PROCEDURE FOR <u>Diazepam Rectal Gel (Diastat)</u> ADMINISTRATION IS ATTACHED</p>		
<p>1. Check one:</p> <p><input type="checkbox"/> I have reviewed and approved the attached standardized procedure as written.</p> <p><input type="checkbox"/> I have reviewed and approved the attached standardized procedure as written with the attached modifications.</p> <p><input type="checkbox"/> I do not approve of LAUSD's standardized procedure. I have attached my alternative procedure and recommendations.</p> <p>2. <input type="checkbox"/> PRN if needed for _____</p> <p>3. Special Instructions: _____</p>		
<p>Authorized Healthcare Provider Authorization for <u>Diazepam Rectal Gel (Diastat)</u> in School Setting</p>		
<p>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.</p> <p>*Authorized Healthcare Provider Name: _____ Signature: _____ Date _____</p> <p>Phone: _____ Address: _____ City _____ Zip _____</p> <p>*Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number _____</p>		
<p>Autorización del padre de familia para administrar <u>Diazepam en Gel Rectal (Diastat)</u> en el entorno escolar</p>		
<p>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:</p> <ol style="list-style-type: none"> 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. <p>Dar consentimiento a la enfermera escolar para comunicarse con el proveedor de servicios de salud cuando sea necesario.</p> <p>Padre de familia/tutor (letra de molde): _____ Firma: _____ Fecha: _____</p> <p>Tel. del hogar: _____ Tel. del trabajo: _____ Celular: _____</p>		
<p>Licensed Nurse Acknowledgement of Complete and Accurate Order</p>		
_____	_____	_____
Printed Name of Nurse	Signature	Title (RN, LVN)
_____	_____	_____
Date		

March 2023