LOS ANGELES UNIFIED SCHOOL
Medical Services Division
District Nursing Services Branch

**Parent Consent and Authorized Healthcare Provider Authorization for TRACHEOSTOMY TUBE REPLACEMENT at School and School-Sponsored Events**

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

**NOTE: STANDARD EMERGENCY CARE PROCEDURE FOR TRACHEOSTOMY TUBE REPLACEMENT IS ATTACHED. PLEASE REVIEW AND SIGN FORM TO INDICATE AUTHORIZATION.**

**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 TRACHEOSTOMY TUBE REPLACEMENT 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: FurnishingNumber** _____

**Parent Consent for Authorization and Management of TRACHEOSTOMY TUBE REPLACEMENT 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 Completeness and Meets District Guidelines**

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

February 2025

LOS ANGELES UNIFIED SCHOOL
Medical Services Division
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| **Student:** | **DOB:** | **Grade:** |
|---|---|---|
| **School:** | **Phone:** | **Fax:** |

**NOTE: STANDARD EMERGENCY CARE PROCEDURE FOR TRACHEOSTOMY TUBE REPLACEMENT IS ATTACHED. PLEASE REVIEW AND SIGN FORM TO INDICATE AUTHORIZATION.**

**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 TRACHEOSTOMY TUBE REPLACEMENT 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** _____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: FurnishingNumber** _____

**Consentimiento del padre de familia para autorizar el proceso de REEMPLAZO DE TUBO PARA TRAQUEOTOMÍA 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 Completeness and Meets District Guidelines**

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

February 2025

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