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

Parent Consent and Authorized Healthcare Provider Authorization for
GASTROSTOMY FEEDING: BOLUS METHOD 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 Gastrostomy Feeding: Bolus Method 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:

☐ Name of feeding:_____ Amount:_____

☐ Amount of water flush: _____

☐ Medication/s via Gastrostomy Tube: ☐ No ☐ Yes (medication authorization/s attached)

☐ Oral feedings: ☐ No ☐ Yes if yes, specify:_____

Authorized Healthcare Provider Authorization for Gastrostomy Feeding: Bolus Method 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 Gastrostomy Feeding: Bolus Method 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:** _____

May 2017

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

Parent Consent and Authorized Healthcare Provider Authorization for GASTROSTOMY FEEDING: BOLUS METHOD at School and School-Sponsored Events

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

NOTE: STANDARD EMERGENCY CARE PROCEDURE FOR GASTROSTOMY FEEDING: BOLUS METHOD 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 _____

3. Special Instructions:

☐ Name of feeding:_____ Amount:_____

☐ Amount of water flush: _____

☐ Medication/s via Gastrostomy Tube: ☐ No ☐ Yes (medication authorization/s attached)

☐ Oral feedings: ☐ No ☐ Yes if yes, specify:_____

Authorized Healthcare Provider Authorization for GASTROSTOMY FEEDING: BOLUS METHOD 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 GASTROINTESTINAL: MÉTODO DE BOLO 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:** _____