LOS ANGELES UNIFIED SCHOOL DISTRICT
District Nursing Services

HEALTHCARE PROVIDER AUTHORIZATION FOR SPECIALIZED HEALTH CARE SERVICES

Student's Name _____ Birth date _____

School _____ Grade/Track _____ School Year _____

Physical condition for which the standardized procedure is to be performed _____

_____ ICD Code _____

Name of standardized procedure _____
(One procedure per form)

1. **Check one**:

   ☐ I have reviewed and approved the attached standardized procedure as written.

   ☐ I have reviewed and approved the attached standardized procedure with the attached modifications.

   ☐ I **do not** approve of the school's standardized procedure.
   I have attached my alternative procedure and recommendations.

2. **Time(s**) to be performed at school: _____ and/or

   ☐ PRN if needed for _____

3. **Special Instructions:**

   ☐ Tube feeding: Type _____ Amount: _____

   ☐ Tracheostomy: degree of dependency _____

   ☐ Oxygen: _____ liters per minute.

   ☐ Precautions, possible untoward reactions, and interventions: _____

_____

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 services may be performed by unlicensed designated school personnel under the training and supervision of the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

_____ _____ _____
CA Licensed Healthcare Provider Signature **Print Name** **Date**

_____ (____)_____
Address **City** **Zipcode** **Telephone**

Print name of Supervising Physician_____ (NP, Midwife, PA)

Furnishing Number_____ (NP/Midwife)

Otorgo consentimiento para el intercambio de información médica vinculada al suministro de tratamientos de salud especializados en la escuela.

Nombre del estudiante_____ Fecha de nacimiento _____

_____ Fecha _____
Firma del Padre/Madre/Tutor