PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Students Requiring Assistance with ADLs in Educational Settings and Sponsored Events

School Year:

This authorization is valid for the current school year only

Student:	**DOB:**	**Date:**
District/Site:	**Teacher/Rm:**	**Grade:**

***Direct Intervention*:** (Assisting student in performing a task)

1. **Oral feeding**:
   - ☐ Feeding evaluation completed: ☐ Yes ☐ No
   - ☐ NPO (nothing by mouth)
   - ☐ Tiny tastes of: ☐ foods ☐ liquids
   - ☐ Thick liquids
   - ☐ Thickener: _____ Amount: _____
   - ☐ Pureed foods
   - ☐ Chopped
   - ☐ Regular
   - ☐ Restrictions: _____
   - ☐ Other: _____
2. **Toileting**:
   - ☐ Per classroom schedule and/or as needed
3. **Diaper Change**:
   - ☐ Per classroom schedule and/or as needed
   - ☐ Barrier Cream

     Name: _____

     Dose: _____ Frequency: _____
4. **Bowel and Bladder Care**
   - ☐ As needed ☐ N/A ☐ Other _____
5. **Dressing/Grooming**
   - ☐ As needed ☐ N/A ☐ Other _____
6. **Bathing (washing face/body)**
   - ☐ As needed ☐ N/A ☐ Other _____
7. **Ambulate/Position/Transfer**
   - ☐ As needed ☐ N/A ☐ Other _____
8. **Cueing, Redirecting, or Monitoring**
   - ☐ As needed ☐ N/A ☐ Other _____
9. **Other:**
10. **Other pertinent information / recommendations signed and attached to this authorization form.**

Reason for Medical Necessity (Diagnosis and/or description of student's physical or cognitive impairment affected):

Authorized Health-Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations.

_____ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization.

***Authorized Health-Care Provider Name** _____ ***NPI Number** _____

Signature _____ **Date**_____

Phone _____ **Address** _____ **City** _____ **Zip** _____

Supervising Physician Name _____ **NPI Number** _____

Phone _____ **Address** _____ **City** _____ **Zip** _____

Parent Consent for Authorization and Management in the Educational Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request that the specialized physical health-care service be administered to my (our) child in accordance with state laws and regulations.

I (we) will:

1. provide the necessary supplies and equipment;
2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and
3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the school nurse to communicate with the authorized health-care provider when necessary.

Parent(s)/Guardian(s) Signature: _____ **Date** _____

_____ **Date** _____

Reviewed by credentialed school nurse (signature) _____ **Date** _____