PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Management of an Ostomy in Educational Settings and Sponsored Events

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

1. **Latex Allergy:**
   ☐ YES
   ☐ No
2. **Type of ostomy:**
   ☐ Ileostomy ☐ Descending
   ☐ Ascending ☐ Sigmoid
   ☐ Transverse
3. **Type of device:**
   ☐ One piece ☐ Drainable
   ☐ Two piece ☐ Closed
   ☐ Both ☐ Flange with skin barrier
   ☐ Other: _____
4. **Size:** ☐ 4x4 ☐ 6x6 ☐ Other: _____
5. **Empty ostomy bag when 1/3 to 1/2 full of air or stool and as needed.**
6. **Change ostomy bag:**
   ☐ Frequency: _____ ☐ as needed
   Peri stoma cleaner: ☐ spray ☐ wipes
   ☐ Adhesive removal wipes
   Skin prep/barrier: ☐ paste ☐ wipes ☐ powder
   ☐ wafer ☐ ring
   ☐ Deodorant/odor eliminator
   ☐ Other: _____
7. **Irrigation**:
   ☐ Time: _____
   ☐ Amount of water: _____
8. **Sports/physical education:**
   ☐ No contact sports.
   ☐ Sports allowed: _____
   ☐ Use protective equipment.
9. **Other pertinent information or recommendations**:

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. Authorizations may be faxed.

***Authorized Health-Care Provider Name** ________________________ ***NPI Number** ___________________________

Signature ____ **Date**___________________

Phone ___________________ **Address** __________________________ **City** ___________________ **Zip** ____________

Supervising Physician Name ____ **NPI Number** _____________________

Phone ___________________ **Address** __________________________ **City** ___________________ **Zip** ____________

☐ I request that the credentialed school nurse provide me with a copy of the completed Individualized Health-Care Plan (IHP).

PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Management of an Ostomy in Educational Settings and Sponsored Events

Student:	DOB:	Date:

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.

I (we) understand that I (we) will be provided a copy of my child's completed Individualized Health-Care Plan (IHP).

Parent(s)/Guardian(s) Signature: ____ **Date** ________________

____ **Date** ________________

Reviewed by credentialed school nurse (signature) ____ **Date** ________________

☐ **Credentialed school nurse has informed principal about health-care services provided for this student.**