



# GRANDVIEW SCHOOL DISTRICT

**Student** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Medication** \_\_\_\_\_  
Estudiante \_\_\_\_\_ Grado \_\_\_\_\_ Medicacion \_\_\_\_\_

**Health Condition** \_\_\_\_\_  
Condicion de salud \_\_\_\_\_

My student no longer needs this medication to be given at school. If this medication was needed to treat a potentially life threatening condition including Asthma, severe allergy, seizure disorder, or diabetes. I understand that I must provide the signature of our licensed health care provider below to verify that the medication is no longer needed. Without this signature, my student may be at risk of exclusion per RCW 28A.210.320.

Mi estudiante ya no necesita este medicamento para ser impartido en la escuela. Si era necesario este medicamento para tratar una potencialmente vida amenazante condicion tales como Asma, alergia severa, trastorno convulsivo, o diabetes. Entiendo que yo debo proporcionar la firma de nuestro proveedor de cuidado de la salud abajo para verificar que esta medicacion ya no es necesario. Sin esta firma, puede ser mi estudiante esta en riesgo de exclusion por RCW 28A.210.320.

Additionally, I will notify the school nurse if my student's health care needs change in the future.

Ademas, notificare a la enfermera la escuela si la salud de mi estudiante cambia en el futuro.

**Parent/guardian signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
Firma del padre

## ∞ To be completed by the Licensed Health Care Provider ∞

Debe ser completado por el proveedor de cuidado de la salud

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I confirm that \_\_\_\_\_ no longer needs the following medication at school:

**Reason Medication is being discontinued** \_\_\_\_\_

**HCP signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**HCP Printed name** \_\_\_\_\_