

Granite Falls School District Health Services

2026-2027 School Year

Dear Parent/Guardian,

During this school year, your student received **Special Health Services**, which may have required the completion of specific health forms. As we approach the end of the current school year, we are preparing for a smooth and safe transition into the next academic year.

Enclosed is a health services packet for your review. Please complete and sign all required forms prior to the first day of school. Having these documents submitted on time helps ensure that we can continue to provide appropriate care and support for your student without interruption.

Medication Administration at school:

If **ANY** medication needs to be taken during school hours, please coordinate with the building nurse at your school. Students are prohibited from carrying medications of any kind on campus without the appropriate forms completed and submitted to the health room.

Requirements include:

- Authorization for Medication Administration **must** be filled and signed by a licensed practitioner (NP, PA, MD or DO) and a parent/guardian dating the start of the school year through the end of the school year
- Unexpired medication **must** be brought to school by parent/guardian in original prescriptive container AND the label on the prescriptive container must match the medical provider's orders
- Medication will be counted with parent/guardian as witness and administered by designated staff as prescribed.
- No more than a 20-day supply of prescribed medications can be checked in at a time.
- **For self-carrying medication:** Demonstration by the student of proper use and technique of medication must be completed with the district or campus nurse prior to self-carrying the medication.
- Controlled substances **CANNOT** be self- carried on any campus.

Life-Threatening Health Considerations:

If your child has a life-threatening health condition that emergency rescue medication administration to be performed at school, you must provide ALL required documents, medication and applicable supplies **prior** to the child attending school in accordance with RCW 28A.210.320. Be sure to contact the school nurse about any health concerns that may impact your child at school.

Summer Nursing Services Contact Info:

Contact information:

Jennifer Leyva, RN
Ph: 360-348-6962

jleyva@gfalls.wednet.edu
425-412-8493- Fax

Hoping you have a restful, healthy, and safe summer!

Respectfully,

Your Granite Falls School District Nursing Team



GRANITE FALLS SCHOOL DISTRICT HEALTH SERVICES

Life Threatening Allergy Assessment Form

Student Name: _____

Date of Birth: _____

Parent/Guardian: _____

Home Phone/Cell Number: _____

Work Phone Number: _____

Does your child's allergy may be **life-threatening**?

No Yes

History and Current Status:

Please list all of your child's known allergies below (*Example: Peanuts, Shell fish, Bees, Latex...*):

How many times has your child had an allergic reaction?

Never Once More Than Once

When was your child's last reaction? _____

Please describe your child's specific presenting allergic reaction symptoms as well as specific treatments used when a reaction may occur (*Be as specific as possible and include what your child may say or do*):

What if any treatment or medication has your health care provider recommended or prescribed for your child's allergic reaction?

Has your child ever received or used an epinephrine auto injector as treatment?

No Yes

Does your child understand that they are allergic to their known allergies and know to avoid them?

No Yes

Does your child know how and when to use the treatment or medication?

No Yes

Please describe any side effects or problems your student had in using the prescribed treatment or medication:

*****If medication is to be kept and administered at school, please have your child's provider complete the attached med authorization form and bring it along with the medication to be checked in, on or before the first day of school.*****

Is there anything else school staff should be aware of?

I give consent to share with the classroom and pertinent staff members that my child has a life-threatening allergy.

No Yes

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Granite Falls School District
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: _____ Grade: _____

**THIS PORTION TO BE COMPLETED BY A LICENSED HEALTH PROVIDER (LHP)
PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY**

(Please clearly print legible instructions)

<u>Name of Medication</u>	<u>Dosage</u>	<u>Method of Administration</u>	<u>Time(s) to Be Take</u>
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Diagnosis or reason for medication: _____

If give PRN, specify the minimum length of time between doses: _____

I request and authorize this student to self-carry their medication. Yes No

I request and authorize this student to self-administer their medication. Yes No

This student has been instructed and has demonstrated the ability to properly manage self-administration of medication.

Possible medication side effects: _____

Emergency procedure in case of serious side effects: _____

I request and authorize the above-named student to be administered the above identified medication in accordance with the instructions indicated above valid for the current school year including summer school unless otherwise indicated. **(not to exceed current school year)**. There exists a valid health reason which may make administration of the medication advisable during school hours.

Date of Signature

Licensed Health Provider (NP, PA, MD or DO)

Name (please print)

Telephone Number

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

- ❖ I request this medication to be given as ordered by the licensed health provider (NP, PA, MD or DO).
- ❖ I give Health Services Staff permission to communicate with the medical office staff about this medication. I understand oral medications may be administered by non-licensed staff members who have been trained and are supervised by a Registered Nurse.
- ❖ Medical information may be shared with school staff working with my child and 911 staff, if they are called.
- ❖ All medication supplied must be brought to school in its original container with instructions as noted above by the licensed health provider.
- ❖ I request and authorize my child to carry and/or self-administer their medication. Yes No

Date of Signature

Parent/Guardian Signature

Telephone numbers: _____ (home) _____ (work) _____
(cell)

Reviewed by GFSD Registered Nurse: _____ Date: _____



Washington Office of Superintendent of

PUBLIC INSTRUCTION

REQUEST FOR SPECIAL DIETARY ACCOMMODATIONS

Student / Participant Name

Date of Birth

Parent / Guardian Name

Phone

Mailing Address

City/State/Zip

School / Center / Site

Grade / Classroom

Signature of Parent/Guardian

Date

Diet Order

Federal law and USDA regulation require nutrition programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal diet preferences.

- 1. Describe how the impairment affects the child** (i.e., how the ingestion/contact with the food impacts the child):
- 2. Explain what must be done to accommodate the child's diet** (i.e., specific food(s) to be omitted/avoided from the child's diet):
- 3. List food(s) and/or beverages to be substituted, provided, or modified:**

**State-Recognized Medical Authority is a licensed health care professional authorized to write medical prescriptions in Washington: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PA) with prescriptive authority, Naturopathic Physician, or Advanced Registered Nurse Practitioner (ARNP).*

Signature of State-Recognized Medical Authority*

Date

Clinic Name