

Granite Falls School District Nursing 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
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>
_____	_____	_____	_____

Diagnosis or reason for medication: _____

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

I request and authorize this student to 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)

Telephone Number Name (please print)

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 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 professional.

❖ 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: _____