

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 HEALTH SERVICES

Jennifer Leyva, RN

District Nurse

Phone: 360-348-6962

Fax: 425-412-8493

Email: jleyva@gfalls.wednet.edu

GRANITE FALLS SCHOOL DISTRICT

Date: _____

To the Parent or Guardian of _____,

In order to update your child's Individual Healthcare Plan (IHP) for next year, I also need an updated school plan from your child's neurologist regarding their seizure diagnosis including daily medication, emergency medications, accommodations and/or recommendations that may be needed for your child at school. Because each student's needs are unique to their condition/diagnosis, I must acquire directions from your child's licensed health care provider to individualize their IHP. If your child does not have any restrictions or limitations, we will need documentation stating so.

If you have any questions or concerns, please contact me at 360-283-4393 ext. 7026.

Thank you so much for your help and time!

Jennifer Leyva, RN

jleyva@gfalls.wednet.edu

District Nurse

Granite Falls School District



GRANITE FALLS SCHOOL DISTRICT HEALTH SERVICES

Seizure History Update

This form is intended to help the school nurse update your student's Seizure Individual/Emergency Health Care Plan.

Student Name: _____

Parent/Guardian Name: _____

Does the student have any important/relevant updates regarding their diagnosis that we should be aware of while updating their IHP for the new school year?

Does the student have a daily or rescue med for their condition? _____

Is this student currently on medication to control seizures? _____

If yes, please list name and dose: _____

*****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.*****

Has this student developed any new seizure triggers in the past year? _____

If yes, please list: _____

What was the date of your student's last seizure? _____

What specific symptoms did your student exhibit during their last seizure?

How many times has this student been to the emergency room for seizures in the past year? _____

How many days would you estimate this student missed school this last year because of seizures?

Thank you,

Granite Falls School District Nursing Staff

Thank you,
Granite Falls School District Nursing Staff
Phone number: 360-348-6962
Fax number: 425-412-8493
Email: jleyva@gfalls.wednet.edu

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 Professional (NP, PA, MD & 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 & 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: _____