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 jleyva@gfalls.wednet.edu
Ph: 360-348-6962 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

Diabetic History Update

This form is intended to help the school nurse update your student's 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 to include in their IHP for the new school year?

_____
_____
_____

Does the student have a daily or rescue medication for their condition? ☐ No ☐ Yes
If yes, list here: *(Example: 24 units Lantus nightly, 3mg Baqsimi)* _____

Does the student require correctional or coverage insulin? ☐ No ☐ Yes
If yes, list here: *(Example: Novolog, NovoPen Echo, Correction Factor 25, Carbohydrate Ratio 10)* _____
_____

Does the student have an insulin pump? ☐ No ☐ Yes If yes, specify brand: _____

Does the student wear a Continuous Glucose Monitor (CGM)?☐ No ☐ Yes
If yes, specify brand, model, app, and connected device? *(Example: Dexcom G7, Dexcom Follow, Receiver)* _____
_____

******If medication is to be kept and administered at school, please have your child's provider create a School Care Plan and bring it along with the medication to be checked in, on or before the first day of school.******

Has this student had any extreme high or low blood sugars in the past year? ☐ No ☐ Yes
If yes, when are these events most likely to occur?

_____
_____
_____

Has the student been in the hospital in the past year for diabetic related issues? ☐ No ☐ Yes
If yes, please describe: _____

What specific signs or symptoms does your student exhibit during high and low blood sugar?

_____
_____

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

_____

Will this student require transportation services (bus)? ☐ No ☐ Yes

Will this student eat a school-provided lunch or a home-provided lunch? ☐ School-provided ☐ Home-provided

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

STUDENT AND HEALTH SERVICES
FAX: 425-412-8493

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)

Name of Medication	Dosage	Method of Administration	Time(s) to Be Take
_____	_____	_____	_____

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:_____

AUTHORIZATION TO RELEASE/OBTAIN/EXCHANGE PATIENT HEALTH INFORMATION

Patient

Patient Name: _____ Date of Birth: _____/_____/_____
Last First Middle Month Day Year

Other Names Used: _____ Medical Record Number: _____
(if applicable) (if known)

Release

I authorize Seattle Children's Hospital to: ☐ Release To ☐ Obtain From ☐ Exchange With (Verbal Information Only)

Organization/Recipient: _____ Attn: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #:(____)_____ Fax #:(____)_____ Email: _____
(required for CD and electronic delivery)

Delivery/Purpose

Paper copies will be mailed to the recipient unless another format is checked below:

☐ CD (compact disc) ☐ Secure Electronic Delivery (patient/family only) ☐ Pick-up (we will call you when records are ready)

Please indicate the purpose(s) of your request:

☐ Continuing Care ☐ Transfer of Care ☐ Personal Use ☐ Legal ☐ Insurance ☐ Disability ☐ School

☐ Other (please specify): _____

Information

Records for Dates:

From _____ -- **To** _____
Month/Year **Month/Year**

If no date is specified, an abstract of records will be released (most recent clinical documentation)

☐ Inpatient Hospital Stay
☐ Outpatient Clinic/Emergency Department
☐ Lab & Radiology Reports
☐ Operative/Procedure Notes
☐ Radiology Images (on CD)
☐ Billing Records

☐ PBMU Summary/Care Plan
☐ Educational Services Summary
☐ Other (please specify)

_____

Notices

I understand that:

- Signing this release of health information is voluntary; I do not need to sign this form for treatment or payment.
- Any disclosure of information has the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- I can cancel this authorization at any time, by informing the Health Information Management department in writing. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.

Signatures

This authorization expires **one year** from the date signed **unless** another date or event is indicated here: _____

Exception: if patient information is to be released to an employer or financial institution, this authorization is only valid for 90 days from the date signed.

Minors (age 13-17) - A minor patient's signature is required below to release the following information: 1) conditions related to reproductive care including, but not limited to, birth control, pregnancy-related services and sexually transmitted infections including HIV/AIDS (age 14 or older) 2) mental health conditions (age 13 and older) 3) drug and alcohol abuse diagnosis or treatment (age 13 and older) (This information is subject to Federal Regulation 42 CFR Part 2 - See reverse for more information).

I specifically authorize Seattle Children's to release health information checked below:

☐ Reproductive Care ☐ Sexually Transmitted Infections (incl. HIV/AIDS) ☐ Mental Health ☐ Drug/Alcohol Abuse

_____ _____ _____
Signature of Minor Patient Printed Name Date Signed

_____ _____ _____
Signature of Patient/Legal Representative Printed Name Relationship to Patient

(_____) _____ _____
Phone Number Date Signed

Staff

Have the records been released to the requestor? ❑ YES ❑ NO Staff Name: _____ Clinic/Unit _____

Please forward the completed authorization to the Health Information Management department (M/S S-216)

Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

PO BOX 5371 MAIL STOP S-216
SEATTLE, WA 98145-5005
PHONE: 206-987-2173 FAX: 206-985-3252

44036

PATIENT LABEL

AUTHORIZATION TO RELEASE/OBTAIN/EXCHANGE PATIENT HEALTH INFORMATION