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 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

Asthma History Update

This form is intended to help the school nurse update your student's Asthma 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 rescue med for their condition?___________________________________

If so, do they self-carry/administer their own 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.*****

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

How do you rate the severity of this student's asthma where 1 is not severe and 10 is severe?_______

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

Has this student developed any new asthma triggers in the past year? ________

If yes, please list:____

Which, if any, of the following aids does this student use for managing asthma? (Please Circle)
Peak flow meter (personal best reading, if known _______) Spacer
Holding chamber with mask Holding Chamber
Other (please specify) ____________________________________

Please indicate by circling any of the special needs below this student has related to asthma:

Physical education class Avoidance of certain foods _______________ Access to water

Observation of medication side effects Transportation to/from school Field trips

If you circled any of the above items, please describe those needs:

____
____
____

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

Fax: 425-412-8493

AUTHORIZATION FOR ADMINISTRATION OF ASTHMA MEDICATION AT SCHOOL

Student Name: ____ Birth Date: __________________________________

School: ____ Grade: _____________________________________

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

(Please clearly print legible instructions)

□ Albuterol: □ 2 puffs □ 4 puffs every four hours as needed for cough, wheezing or shortness of breath. Repeat if not improved in 20 minutes.

□ Levalbuterol (Xopenex): two puffs every four hours as needed for cough, wheezing or shortness of breath. Repeat if not improved in 20 minutes.

□ If acute SOB may give one treatment of rescue inhaler every 2 hours.

□ Other Medication: ____

□ Use _________ minutes before exercise/PE.

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 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 Registered Nurse: ____ Date: ________________