Student Health Services

Student's Name _____ Birth Date _____

Student ID # _____ School _____ Grade _____

School Nurse _____ Phone _____

Date: _____

Dear Licensed Health Care Provider

Extraordinary nursing support has been requested for this student during the school day. In order to have a consistent and transparent process for the determination of the need for extraordinary nursing support, **please complete the attached form**.

As described by the Washington State Nursing Commission and the Office of the Superintendent of Public Instruction (OSPI) in the *Staff Model for the Delivery of School Health Services*, the acuity of students who require extraordinary nursing support during the school day can be described in the following ways:

Level A: Nursing Dependent – Requires 1:1 skilled nursing care *24 hours/day* to prevent irreversible damage or death. Requires immediate availability (audible and visual range) of RN or LPN and nursing support during transportation

Level B: Medically Fragile – daily faces the possibility of life-threatening emergency requiring the skill and judgment of a professional nurse. Needs a *full time nurse accessible in the building*

- **B1** – requires skilled nursing support for transportation
- **B2** – requires skilled nursing support for field trips; short transportation without nurse acceptable with nurse check in before release to bus
- **B3** – Accommodations allow placement at non-Level B site (PDA; 911; parent provided care)

Level C: Medically Complex - Daily skilled nursing care not required but an assessment at least annually is needed.

Please use the attached form to describe the skilled nursing needs of the student above.
Your input is highly valued. Thank you for your prompt response.

Sincerely,

Russel Palumbo BSN RN
Manager, Student Health Services, Seattle Public Schools
rupalumbo@seattleschools.org

Student Health Services

Licensed Health Care Provider

Request for Extraordinary Nursing Services

Student's Name _____ Birth Date _____

Student ID # _____ School _____ Grade _____

School Nurse _____ Phone _____

☐ Initial Request ☐ Annual Renewal Request

BELOW TO BE COMPLETED BY HCP

Diagnosis: _____

Summary of skilled nursing needs during the school day: _____

_____

_____

Please check the box(es) that indicate the level of nursing service you determine is medically necessary for this student

☐ **Level A: Nursing Dependent** – Requires 1:1 skilled nursing care *24 hours/day* to prevent irreversible damage or death. Requires immediate availability (audible and visual range) of RN or LPN and nursing support during transportation

☐ **Level B: Medically Fragile** – daily faces the possibility of life-threatening emergency requiring the skill and judgment of a professional nurse. Needs a *full time nurse accessible in the building* **and**

- ☐ **B1** – requires nursing support for transportation
- ☐ **B2** – requires nursing support for field trips; short transportation without nurse acceptable with nurse check in before release to bus
- ☐ **B3** – Accommodations allow placement at non-Level B site (PDA; 911; parent provided care)

☐ **Level C: Medically Complex** - Daily skilled nursing care not required but an assessment at least annually is needed.

I certify that it is medically necessary for the named student to have the level of nursing service indicated by the checked box.

Health Care Provider Signature _____ Date _____

HCP Name _____ Phone _____ FAX _____

Address _____ City _____ Zip Code _____