WVEIS
STUDENT DATA COLLECTION FORM

Student Name _____
Last First Middle Other Sex

Date Enrolled_____ SS #_____

Birth Date_____ Birth Place (City, State) _____

Transfer From (City, State) _____

*Class E1 0K 01 02 03 04 05
06 07 08 09 10 11 12

Transportation Mode: 01= Bus Student 02= Non-Bus Student

Morning Bus_____ Evening Bus_____

Homeroom_____ Homeroom Teacher_____

Native Language_____ EN=English SP=Spanish OT=Other

Hispanic _____ Race Options (Y/N): White_____ Black_____ Asian_____ Amer-Ind_____ Pacific_____

Primary Family Phone #_____

Parent/Guardian_____

Physical Address_____

Mailing Address_____

Employer _____Occupation_____

Work #_____Cell#_____Email_____

Alternate Contact/s	Relation	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician_____ Phone #_____

Special Instructions:

_____

_____

_____

_____

WEST VIRGINIA DEPARTMENT OF EDUCATION
Council of School Nurses
ADMINISTRATION OF MEDICATION FORM
McDowell County Schools

School Year _____ (Includes Extended School Year/Summer Programs)

Student Name: _____ DOB: _____ Grade: _____ School: _____

TO BE COMPLETED BY LICENSED PRESCRIBER (A separate administration of medication form is required for each medication)

Diagnosis: _____ Allergies: _____

Medication: _____ Dosage: _____ Time: _____ Route: _____

Intended Use: _____ Possible Side Effects: _____

Other Prescribed Medications: _____

Initial if this medication can be administrated by trained unlicensed personnel _____

Initial if student may self-administer this medication in accordance to policy _____

Initial if student may carry this medication on his/her person in accordance to policy _____

Prescriber's Name (print): _____ Telephone Number: _____ Fax Number: _____

Prescriber's Signature: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I understand that, whenever possible, all medications should be given at home. I give permission for my child to take the above medication at school according to county policy. I understand that a photograph may be taken and utilized to assist in the medication administration process. I further understand that the school, county board of education and its employees and agents are exempt from any liability, except for willful and wanton conduct, as a result of any injury, loss to persons or property, arising from the self-administration of medication by the student. I also agree to indemnify and hold harmless the school, the county board of education and its employees and agents against any claims arising from medication administration and/or self-administration of medications.

The medication must be hand delivered by the parent/guardian to designated school personnel, in original labeled pharmaceutical container or manufactured labeled container.

Parent/Guardian signature to approve administration of medication: _____

Date: _____

McDowell County Schools
Physician Order & Parent Request
Specialized Health Care

Student: _____ Birthdate: _____ School: _____ Grade: _____

School Nurse: _____ Telephone: _____ Fax: _____

West Virginia State law requires direct orders from a physician for any specialized procedure needed by a student during school hours. These orders will be carried out for one school year period, unless a change is indicated by the physician.

Specialized Health Care Procedure: _____

_____

_____

_____

Special Equipment (Include size of catheters, cannulas, etc.)

_____

_____

_____

Any special instructions:

_____

_____

_____

Has student been instructed in self-care relative to the procedure: Yes_____ No_____

May student perform procedure independently: Yes_____ No_____

Physician Signature: _____

Telephone: _____ Fax: _____

Physician Name and Address (Please Print)

_____

_____

_____

Signature of parent indicated approval of above procedure to be done in school by a certified school nurse and/or designated trained personnel.

Parent/Guardian Signature: _____

Date: _____ Telephone Number: _____

MCDOWELL COUNTY PUBLIC SCHOOLS EMERGENCY INFORMATION/HEALTH ASSESSMENT FOR SCHOOL YEAR 20_____ - 20_____

(TO BE COMPLETED EACH YEAR)

Student _____ DOB_____ S.S.# _____School _____ Grade_____

Parent/Guardian _____Home Phone _____Work Phone _____

Address _____ Gender M or F

Home Directions _____

List (2) relatives or neighbors who will assume temporary care of your child and/or who would be able to reach you in the event of an emergency -list additional names on back of page

Name_____ Phone_____

Name_____ Phone_____

In the event my child becomes seriously ill or injured and none of the above contacts can be reached the school personnel, physician and hospital are hereby authorized to render any treatment necessary for the emergency care of my child.

_____

Signature of Parent/Guardian Date

PLEASE CHECK OR LIST ANY CONDITION YOUR CHILD HAS SEEN A PHYSICIAN FOR:

Respiratory (Including asthma & bronchitis) _____

Allergic reaction (bee stings/foods/foods/medications/latex) _____

Seizures _____

Heart Problems _____

Blood Disorders (Including frequent nose bleeds) _____

Hearing (including frequent ear infections) _____

Vision (Including eye surgery &/or glasses) _____

List any medication your child is taking for any of the above conditions-write NONE if no medication is taken/needed
List any other medications taken and any other health condition not mentioned above

_____

_____

_____

Physician Name_____Phone#_____ Date of Last Exam_____

Dentist Name _____ Phone # _____ Date of Last Exam_____

Health Insurance (Y/N) _____ Insurance Type_____

Copy of student's immunization record attached _____ Yes _____ No

No medication will be given at school without a current medication order signed by your child's doctor and you. Medication must also be in a properly labeled container from the pharmacy. If you have any questions contact your school nurse.

IMMUNIZATION CONSENT FORM

West Virginia Law requires parents to show proof that their children have received certain vaccinations before being admitted to school. WV Code §16-3-4 plus two legislative rules give clear guidance on which vaccinations and how many doses are required for school entry. Those rules are; Reportable Diseases, Events and Conditions, 64CSR7, and, Immunization Requirements and Recommendations for New School Enterers, 64CSR95.

The West Virginia Bureau for Public Health began a program in 1999 to help parents keep track of their children's shots. This program is called WVSIIS (West Virginia Statewide Immunization Information System). Some children's shot records have been reported by doctors and entered into the WVSIIS database. However, not all records have been reported, particularly for children born before 2003.

Maintaining your child's shot records in WVSJIS helps schools, doctors and families. It makes important historic information available to parents and doctors as to which shots your child has had and which ones are needed. Keeping your child's records in WVSIIS minimizes the chance that your child will ever have to repeat any immunizations when proof of immunization may be required for college admission, certain occupations, or during a disease outbreak.

Providing immunizations for all school children helps to keep your child, your community and our schools free from preventable diseases. The WVSIIS program plays a crucial role by providing for the safe, accurate and confidential maintenance of your child's immunization records.

Please indicate below that you consent to have your child's or children's school immunization records kept in the WVSIIS by checking the box below and signing this form. Thank you.

☐ Yes, I give permission for the school to share my child's shot records with WVSIIS.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Printed name and Address of Parent of Legal Guardian

1. _____
   Child's Name Child's Date of Birth

2. _____
   Child's Name Child's Date of Birth

3. _____
   Child's Name Child's Date of Birth

4. _____
   Child's Name Child's Date of Birth

If consent is being given for more than four children, please use an additional sheet.

West Virginia Immunization Requirements for New School Enterers

State law and rules[1] require that all children entering school in West Virginia for the first time in grades K-12 must show proof of immunization against diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, varicella, and hepatitis B unless properly medically exempted[2]. The table below outlines immunization requirements as most commonly met.[3] The West Virginia Bureau for Public Health recommends that vaccine doses administered 4 days or fewer before the minimum interval or age should be considered valid.

Vaccine	Requirements	Provisional Enrollment	Additional Information
DTaP/DTP Td/Tdap	Before admission, four doses required. One dose must be after the 4th birthday.	After one dose, student may be allowed up 8 months to complete the series if necessitated by the minimum intervals of the vaccine schedule.	• Three doses only for children completing primary series at age 7 years and older. • Children exempted from the pertussis component of DTaP vaccine should receive DT vaccine instead, or if past 7th birthday, Td / Tdap vaccine, as applicable.
Polio (IPV)	Before admission, three doses required. One dose must be after the 4th birthday.	After one dose, student may be allowed up 7 months to complete the series if necessitated by the minimum intervals of the vaccine schedule.	• If polio immunization series included both OPV and IPV, then a total 3 of 4 doses are required depending upon the age of the child.
Measles, Mumps & Rubella (MMR)	Before admission, two doses required. First dose must be after the 1st birthday.	After one dose, student may be allowed up to 30 days to complete the series.	• Doses should be a minimum of 28 days apart.
Varicella	Before admission, two doses required. First dose must be after the 1st birthday.	After one dose, children **less than 13 years of age** may be allowed up to 90 days to obtain 2nd dose; children aged **13 years and older** may be allowed up to 30 days to obtain the 2nd dose.	• Children less than 13 years of age are recommended to have an interval of 12 weeks between the 1st and 2nd doses, **however**, an interval of at least 4 weeks is acceptable. • Children aged 13 years and older may receive the 2nd dose 28 days after the first dose. • Immunity may also be demonstrated through the legal guardian's written or verbal attestation of varicella (chickenpox) disease.
Hepatitis B	Before admission, three doses required. Last dose must be after the age of 6 months.	After one dose, student may be allowed up to 4 months to complete the series if necessitated by the minimum intervals of the vaccine schedule.	• Final dose is not valid if administered before 24 weeks / 6 months of age.

1. See WV Code §16-3-4 and 64CSR95 for further information.
2. Medical exemptions must be requested by a physician who has treated or examined the child and be reviewed and submitted to the Immunization Officer of the Bureau for Public Health. Requests for exemptions must be based on current standards of immunization practice and include the following information: the vaccine(s) being exempted, the specific medical reason for the exemption, whether the exemption is temporary or permanent, and, if temporary, when the exemption should be reevaluated. West Virginia State Law does not allow for non-medical exemptions to immunization requirements.
3. Occasionally, based on product used or the age at which a child is being immunized, deviations from these requirements may be acceptable. Any deviation must be consistent with applicable, age appropriate immunization schedules found at http://www.cdc.gov and searching under "Immunization Schedules".

Health & Human Resources

National Center on
Health, Behavioral Health, and Safety

Head Start Oral Health Form—Children

Patient Information

Child's name | Date of birth | Parent's/guardian's name | Phone number

Address | City | State | Zip code

This practice is the child's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including filling , crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Risk assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ☐ Yes ☐ No
Silver diamine fluoride: ○ Yes ○ No
Dental sealants: ○ Yes ○ No

Counseling/Anticipatory Guidance

○ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Silver diamine fluoride: ☐ Yes ☐ No
Crowns: ○ Yes ○ No
Extractions: ☐ Yes ○ No
Emergency care: ☐ Yes ○ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* | Phone number | Fax number

Practice name | Address

Provider signature | Date of service

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FERPA/HIPAA CONSENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICALPROVIDERS and SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):
(1) _____ (2) _____
to provide health information from the above-named child's medical record to and from:

_____ _____
School District to Which Disclosure is Made Address / City and State / Zip Code

_____ _____
Contact Person at School District Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following: ☐ All minimum necessary health information; or
☐ Disease-specific information as described:

_____

DURATION:

This authorization shall become effective immediately and shall remain in effect until_____(enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

_____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient/Student Area Code and Telephone Number

1900 Kanawha Boulevard, East, Building 6 • Charleston, WV 25305
wvde.us

Children with Disabilities and Special Dietary Needs

Schools/Sites participating in a federal school meal program (National School Lunch Program, School Breakfast Program, Child and Adult Care Food Program, Summer Food Service Program, Fresh Fruit and Vegetable Program, Special Milk Program, and Afterschool Snack Program) are required to make reasonable accommodations for children who are unable to eat the school/site meals because of a disability that restricts the diet.

1. Licensed Medical Authority's Statement for Children with Disabilities

U.S. Department of Agriculture (USDA) regulations at 7 CFR Part 15b require substitutions or modifications in school/site meals for children whose disabilities restrict their diets. School Food Authorities/Sponsors must provide modifications for children on a case-by-case basis when requests are supported by a written statement from a state licensed medical authority.

The third page of this document **("Medical Plan of Care for School/Site Food Service")** may be used to obtain the required information from the licensed medical authority. For this purpose, a *state licensed medical authority* in West Virginia includes a:

- Physician, (MD or DO)
- Physician assistant,
- Certified registered nurse practitioner, or
- Dentist.

The written medical statement must include:

- An explanation of how the child's physical or mental impairment restricts the child's diet;
- An explanation of what must be done to accommodate the child; and
- The food or foods to be omitted and recommended alternatives, if appropriate.

2. Other Special Dietary Needs

School/Site food service staff may make food substitutions for individual children who do not have a medical statement on file. Such determinations are made on a case-by-case basis and all accommodations must be made according to USDA's meal pattern requirements. Schools/Sites are encouraged to have documentation on file when making menu modifications within the meal pattern.

3. Rehabilitation Act of 1973 and the Americans with Disabilities Act

Under Section 504 of the *Rehabilitation Act of 1973*, the *Americans with Disabilities Act (ADA) of 1990* and the *ADA Amendments Act of 2008,* a person with a disability means any person who has a physical or mental impairment that substantially limits one or more major life activities or major bodily functions, has a record of such an impairment, or is regarded as having such an impairment. A physical or mental impairment does not need to be life threatening in order to constitute a disability. If it limits a major life activity, it is considered a disability.

Major life activities include, but are not limited to: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including but not limited to: functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

4. Individuals with Disabilities Education Act

A child with a disability under Part B of the *Individuals with Disabilities Education Act* (IDEA) is described as a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who, by reason thereof, needs special education and related services. The Individualized Education Program (IEP) is a written statement for a child with a disability that is developed, reviewed, and revised in accordance with the IDEA and its implementing regulations. When nutrition services are required under a child's IEP, school officials need to ensure that food service staff is involved early in decisions regarding special meals.

Nutrition Program Contact
For more information about requesting accommodations to meals and the meal service for children with disabilities at (School or Site Name), please contact:
(Name and contact information)

USDA Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. (mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410;

2. fax: (202) 690-7442; or

3. email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Medical Plan of Care for School/Site Food Service

Please read pages 1 and 2 before completing this form.

Child's Name	Date of Birth	Grade Level/Classroom

Name of School/Site	WVEIS Number

Name of Parent/Guardian	Phone Number of Parent/Guardian

Signature of Parent/Guardian	Date

1. **Provide an explanation below of how the child's physical or mental impairment restricts the child's diet:**

2. **Describe the specific diet or necessary modifications prescribed by the state licensed medical authority to accommodate the child's needs:**

3. **List the food or foods to be omitted (please be specific) and recommended alternatives, if appropriate.**
   Foods to be omitted:
   1-
   2-

Suggested substitutions:
1-
2-
3-

4. **Indicate texture modifications, if applicable:**
   - o Chopped/Cut into bite-sized pieces
   - o Diced
   - o Finely Ground
   - o Pureed
   - o Other: _____

5. **List any required special adaptive equipment:**

Name of Physician/Medical Authority & Title (Please Print)	Provider Phone Number

Signature of Physician/Medical Authority	Date

Signing the following section is optional, but may prevent delays by allowing the school/site to speak with the physician/medical authority.

Health Insurance Portability and Accountability Act Waiver

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act, I hereby authorize _____ (medical authority) to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____ (child nutrition program) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child with the school/site program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____ (date). This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent, guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Signature:_____ Date:_____