PUTNAM COUNTY SCHOOLS
Achieving Excellence

—CONFIDENTIAL—

Medication Order for West Virginia Public Schools — Putnam County (HS-18)

SCHOOL YEAR _____ (Includes Extended School Year/Summer Program)

Student Name: _____ **Birthdate:** _____

Grade: _____ **Teacher:** _____

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 administered 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 (please print): _____

Telephone Number: _____ Fax Number: _____

Prescriber's Signature: _____ Date: _____

This form must be filled out and signed by a licensed prescriber and the parent/guardian for all medication to be given in the school setting. A separate order is required for each medication and orders are good for the current school year only. All medication changes (dosage, time, etc.) require the completion of another form. A photograph of this student may be taken to assist in the correct administration of medication. Medication may be given by unlicensed school personnel to whom the nurse has delegated medication administration and trained to administer medication. All medication must be sent to school in the original container bearing the student's name. Medication will not be administered at school if information is incomplete.

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 also understand and agree that the school nurse may talk with the clinician and his or her staff, as well as school personnel, regarding the student's condition and administration of this medication and its effects. I further understand that the school, county school board and its employees and agents are exempt from any liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the student and agree to indemnify and hold harmless the school, the county board of education and its employees or guardians and agents against any claims arising from the self-administration of medication.

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

Parent/Guardian signature to approve administration of medication _____

Daytime phone number _____

White—School
Yellow—Health Services

Revised 11/21

RETAIN ALL RECORDS

SPECIAL DIETARY NEEDS MEDICAL STATEMENT

Student's Name_____ **DOB**_____ **School**_____ **County**_____ **WVEIS#**_____

* Does this patient have a disability that affects her/his diet? Yes or No Diagnosis _____

*Does this patient have a non-disabling medical condition that affects his/her diet? Yes or No Diagnosis _____

Did you refer this patient's family to receive diet education? Yes or No

If yes, to whom: ☐MD ☐ RN ☐ RD ☐ CDE Name_____ Phone _____

Diet Information sent to: ☐School Nurse ☐ School Cook ☐Child Nutrition Director ☐Principal ☐Other

PLEASE MARK ONLY THE AREAS THAT APPLY:

Schools or sites may make substitutions for individuals with a non-disabling medical condition who are unable to consume the regular meal because of medical or other special dietary needs.

☐ FOOD ALLERGIES:

- _____
- _____
- _____

☐ SUBSTITUTIONS MUST BE LISTED

- _____
- _____
- _____

☐ CALORIC REQUIREMENTS: Please indicate the calories for each meal provided at school.

Daily Total	Breakfast	Lunch	Snack
1200	_____	_____	_____
1500	_____	_____	_____
1800	_____	_____	_____
2000	_____	_____	_____

☐ SODIUM RESTRICTION (Specify Milligrams):_____

☐ CARBOHYDRATE COUNTING (Specify Grams):

Breakfast _____ Lunch _____

☐ OTHER RESTRICTIONS:

- _____
- _____
- _____

☐ TEXTURE CONSISTENCIES for swallowing or chewing difficulties

SOLIDS	LIQUIDS
☐ Regular Chopped	☐ Regular Consistency
☐ Mechanical soft with ground meat	☐ Honey Consistency
☐ Mechanical soft with chopped meat	☐ Nectar Consistency
☐ Pureed	☐ Pudding Consistency

☐ NUTRITIONAL SUPPLEMENTS TO BE PROVIDED AT SCHOOL OR SITE **(for Breakfast and Lunch Only)**

Oral Feedings/Tube Feedings_____ Please specify amount and frequency of feeding _____

*Additional Comments:_____

Disability

- If an individual with a disability requires a special diet, the United States Department of Agriculture requires a medical statement form completed and signed by a licensed physician: medical doctor (MD) or doctor of osteopathic medicine (DO). An updated medical statement must be provided annually or when any change is prescribed.

Non-Disabled Medical Condition

- If an individual has a medical condition requiring a special diet and is medically certified, the school food service **may** make substitutions to the regular diet on a case by case basis. A medical statement is required and must be completed by a medical doctor (MD), doctor of osteopathic medicine (DO), physician's assistant (PA), or nurse practitioner (ANP) and include substitutions to the regular menu. An updated medical statement must be provided annually or when any change is prescribed.

*** See Attached Definitions.**

Sign Here:

_____
Provider Name & Title (print)

_____
Signature, Credentials Date

_____
Provider Phone

_____
Parent/Guardian Name (print)

_____
Signature Date

_____
Parent/Guardian Phone