Seymour R-II School District

416 East Clinton Avenue
Seymour, Missouri 65746
Phone: 417-935-2287 Fax: 417-935-4060

School Superintendent:	**D. Bruce Denney**	**Elementary School Principal:**	**Vicky Denney**
High School Principal:	**Brian Wilbanks**	**Special Education Director:**	**Lessli Pruett**
Middle School Principal:	**Brian Bell**	**Athletic Director:**	**Brandon Weiss**

STUDENT CARRYING MEDICATION REQUEST FORM

The Seymour R-II School District recognizes students may need to carry and use his/her own rescue medication for certain health conditions such as asthma, anaphylaxis, or other chronic health conditions. Medication is permitted in accordance with district policy. Prescription medication should be properly labeled with prescription label that includes student name, name of medication, dosage, frequency of administration, route of administration, diagnosis, and prescriber's name. Student's physician must authorize self-carried/administered medication. When possible, the order should include potential adverse effects and applicable emergency instructions. Please fill out information below.

STUDENT NAME:_____ DATE OF BIRTH: _____ GRADE:_____

MEDICATION NAME: _____

DATE FIRST DOSE OF THIS MEDICATION TAKEN: _____

REASON FOR MEDICATION TO BE GIVEN: _____

_____

WHEN MEDICATION SHOULD BE TAKEN:_____ DOSE: _____

HOW MEDICATION IS TO BE TAKEN? _____
(Example: by mouth, by inhaler, with food, after meals)

PHYSICAN:_____ PHONE: _____

PHARMACY: _____ PHONE: _____

RESPONSIBILITIES FOR CARRYING MEDICATION

Yes No Health Care Action Plan Complete
Yes No Demonstrated correct use/administration of medication
Yes No Recognizes proper and prescribed timing for medication
Yes No Verbalizes importance of not sharing medication with others
Yes No Keeps medication in agreed location
Yes No Keeps a second labeled container in the health office
Yes No Agrees to come directly to the health office if having the following symptoms after using medication:

_____

The student may carry the above mentioned medication unless he/she fails to follow the above agreement.

Student Signature:_____ Date: _____

School Nurse Signature: _____ Date: _____

I request my child be allowed to carry his/her medication and be responsible for its proper storage and use. I will support by child to follow the above agreement and will be contacted to develop a new plan if agreement is not followed.

Signature of Parent/Guardian: _____ Date:_____

Revised: 3/17