**Seymour R-II School District**
**416 East Clinton Avenue**
**Seymour, Missouri 65746**
**Phone: 417-935-2287 Fax: 417-935-4060**

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| **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** |


# MEDICATION ADMINISTRATION REQUEST FORM

Only medications medically necessary should be given during schools hours. School personnel will not administer the initial dose of any medication unless in an emergency. School personnel are not responsible for any ill effects which might occur from this medication.

Over the Counter Medication: Medication should be in the properly labeled original container with student's first and last name. Any over the counter medication needed longer than two weeks must be reviewed with the nurse and may require an order from a provider.

Prescription Medication: Medication should be properly labeled with a prescription label that includes student name, name of medication, dosage, frequency of administration, route of administration, and prescriber's name. An order from the provider prescribing the medication should be given to the school nurse. When possible, the order should include potential adverse effects and applicable emergency instructions.

DATE: _____________

STUDENT NAME:_________________________________________________DATE OF BIRTH: ________________

MEDICATION NAME: ____________________________________________________________________________

WHEN WAS THE FIRST DOSE OF THIS MEDICATION TAKEN? _________________________________________

REASON FOR MEDICATION TO BE GIVEN: _________________________________________________________
______________________________________________________________________________________________

**IF ASTHMA IS THE REASON FOR THE MEDICATION TO BE TAKEN, AN ASTHMA ACTION PLAN IS REQUIRED FROM THE PROVIDER.**

TIME TO BE GIVEN:____________________ DOSE TO BE GIVEN: ______________________________________

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

DATE MEDICATION TO BE GIVEN: ___________________TO_______________________

PHYSICAN (if prescribed):__________________________________________PHONE: ________________________

PHARMACY: _____________________________________________PHONE: _______________________________

I request Seymour R-II School District personnel to administer the above medication to my child. I acknowledge the school district and its employees shall incur no liability as a result of any injury arising from the above medication. However, we also acknowledge the above statement shall not be construed as a release from liability for negligence.

Signature of Parent/Guardian: _______________________________________________ Date:_____________________

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Office use only: Doctor's Order Needed: Yes No Doctor's order on File: Yes No

Revised: 3/17