# PRN Medication Record

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Teacher</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication #1</td>
<td>Medication #2</td>
<td></td>
</tr>
<tr>
<td>Dosage and Time</td>
<td>Dosage and Time</td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Staff Signature and Initials:</th>
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</thead>
</table>
Authorization to Give Medication

Dear Parent/Legal Guardian:

Medication should be given at home when possible. In order for school personnel to administer any type of medicine to your child, we must have on file a signed affidavit giving your permission for us to do so. The medicine must be sent to school with complete instructions and in the original container, which must have the prescription label attached. Please be sure to complete all information that is listed on the form below before returning it to school. This authorization will be honored through the end of the current school year only.

Date: ___________________  Student: ___________________

I hereby request M.S.D. of Mt. Vernon personnel to give my child medication that has been prescribed by Dr. __________________________

Date of last office visit: ___________  Physician's Phone Number: ___________

Starting Date of Medication: ___________  Ending Date of Medication: ___________

Reactions or Side Effects of Medication: ____________________________________________

Instructions for giving my child this medicine.

1. Name of medicine: ___________________________________________________________

2. Dosage to be given: _________________________________________________________

3. Time of day for dosage: _____________________________________________________

4. Special Instructions: _______________________________________________________

I give permission for _________________________________ to pick up medication at school and transport it home.

I give permission for the above information to be verified with my physician.

Parent/Legal Guardian's Telephone Number: _________________________________

Signature of Parent or Legal Guardian: _________________________________
AUTHORIZATION TO GIVE MEDICATION FORM

Dear Parent/Legal Guardian:

Medication should be given at home when possible. In order for school personnel to administer any type of medicine to your child, we must have on file a signed affidavit giving your permission for us to do so. The medicine must be sent to school with complete instructions and in the original container, which must have the prescription label attached. Please be sure to complete all information that is listed on the form below before returning it to school.

***This authorization will be honored through the end of the current school year only.***

Date: ___________________________ School: ___________________________ Student: ___________________________

I hereby request M.S.D. of Mt. Vernon personnel to give my child medication that has been prescribed by Dr. ___________________________.

Date of last office visit: ___________________________ Physician’s Phone Number: ___________________________. Starting Date of Medication: ___________________________.

Ending Date of Medication: ___________________________ Reason medicine is needed: ___________________________.

Reactions or Side Effects of Medication:

Instructions for giving my child this medicine:

1. Name of medicine: ___________________________ 2. Dosage to be given: ___________________________

3. Time of day for dosage: ___________________________ 4. Special Instructions: ___________________________

I give permission for the above information to be verified with my physician.

Parent/Legal Guardian’s Telephone No.: ___________________________ Wk: ___________________________ Emergency: ___________________________

Signature of Parent or Legal Guardian: ___________________________