AO-272
5/01

PRN MEDICATION RECORD

Student's Name _____ **Teacher** _____ **Year** _____

Medication #1 _____ **Medication #2** _____

Dosage and Time **Dosage and Time**

Staff Signature and Initials:

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: _____

AO-274
5/01

Metropolitan School District of Mt. Vernon

MEDICATION RECORD: ADMINISTRATION

Write time and initial. Sign and date at top only once to identify initials.

Signature of Staff Administering Meds.	Initial	Date	Codes (Chart Reason)		Amt. Rec'd	Date	Amt. Rec'd	Date	Amt. Rec'd	Date
			X:No School	F:Field Trip						
			A: Absent	D:Early Dismissal						
			N:None Available	W:Dose Withheld						
			PC:Parent Called	O:No Show						

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug.																															
Sep																															
Oct.																															
Nov.																															
Dec.																															

Date Medication Dosage Time Special Instructions

#1 _____

#2 _____

#3 _____

#4 _____

Student Name _____ Teacher/Grade/ID# _____ Physician _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Jan.																															
Feb.																															
Mar.																															
Apr.																															
May																															

Medication #1: _____ #2: _____ #3: _____ #4: _____

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: _____