Weldon City Schools

RECEIPT OF MEDICATION DELIVERED TO SCHOOL

Student Name: ____ **DOB:** __________________
Teacher: ____ **Grade:** __________________

INITIAL MEDICATION DELIVERY

Name of Medication: ____

Date: ________ Dosage: ________________________ Time to be given: _____________

❑ Healthcare Provider Order Received ❑ Parent Permission Received

Number of Pills Received (if count is appropriate): ______________________________

School Nurse Signature: ____

Parent / Guardian Signature: ____

SUBSEQUENT MEDICATION DELIVERY

Date: ________ Number of Pills Received (if count is appropriate): ______________________

School Nurse Signature: ____

Parent / Guardian Signature: ____

Date: ________ Number of Pills Received (if count is appropriate): ______________________

School Nurse Signature: ____

Parent / Guardian Signature: ____

Date: ________ Number of Pills Received (if count is appropriate): ______________________

School Nurse Signature: ____

Parent / Guardian Signature: ____

Date: ________ Number of Pills Received (if count is appropriate): ______________________

School Nurse Signature: ____

Parent / Guardian Signature: ____