

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: _____