

WCV CSD Receipt for Return of Medication to Parent/Guardian

RECEIPT FOR RETURN OF MEDICATION	
Student Name: _____	DOB: _____
Nurse: _____	Grade: _____
Name of Medication: _____	Dosage: _____
Number of Pills Returned (for controlled substances only): _____	
School Nurse Signature: _____	Date: _____
Parent / Guardian Signature: _____	Date: _____

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