

Student Name: _____ CSISD ID Number: _____ School Year _____

DOB: ____ - ____ - ____ Allergies: _____ Grade: _____ Primary Homeroom: _____

FOR CLINIC USE ONLY: ☐ Entered in eSchool ☐ Teacher notified / ☐ IHP (if applicable)

Medication Count:

Date	Count	Nurse signature	Parent/Witness signature	Date	Count	Nurse Signature	Parent/Witness signature

Comments:

Date	Comment	Date	Comment

Date Medication Returned to Parent or Student:

Medication: _____

Medication: _____

Parent or Student Signature: _____

Nurse Signature: _____

Medication Wasted (Disposed) on Date:

Medication and Quantity: _____

Medication and Quantity: _____

Nurse Signature: _____

Witness Signature: _____

Date Reviewed:	RN/LVN Printed Name	RN/LVN Signature/Initials