

\_\_\_\_\_ School

Receipt of Medication Form

Name of Student: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Delivery made by:

Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_

Medication: \_\_\_\_\_ Quantity: \_\_\_\_\_

Date received: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_

Received & Quantity verified by: \_\_\_\_\_

(Staff member name and title)

For office use only

Is this a change in dosage? Yes \_\_\_\_\_ No \_\_\_\_\_

Does this require a change in administration? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, initial that all persons involved in medication administration have been notified of this change \_\_\_\_\_ Date of notification \_\_\_\_\_