SCHOOL HEALTH SERVICES

MEDICATION AND SUPPLY FORM

Student Name: ___________________________________ Student #: ______________ DOB: ____________
Last First Middle

School:____ School year:_______

The following medications and/or supplies were delivered to the school by the parent/guardian

Medication and/or supplies	Date	Pill count, amount of liquid, or supplies	Expiration date of medication and/or supply	Signature of the person who delivered the medication or supply	Relationship to student student	Signature of the employee who counted the medication or supply	Signature of the employee who witnessed medication or supply count

The parent/guardian picked up the following medications and/or supplies.

Medication and/or supplies	Date	Pill count, amount of liquid, or supplies	Signature of person who picked up the medication or supply	Relationship to student	Signature of employee who counted the medication or supply	Signature of employee who witnessed medication or supply count