



Tracking Documentation of Medications/Supplies Received

Name of Student to Receive Medication

Date Medication Sent: _____

Signature of Parent/Guardian/Home Staff Sending in Medication

Parent/Guardian/Staff Signature

Name of Medication/Supplies: _____

Number of Tabs/capsules/Vials/Tubes, etc.: _____

Dosage/Strength/Concentration: _____

Frequency/Time to be Administered: _____

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Date Received: \_\_\_\_\_

Number Received: \_\_\_\_\_

Confirming Staff Signature: \_\_\_\_\_

***All medication must be in original labeled container***

**A separate form MUST be completed and accompany *each* medication sent into facility. Medication(s) will NOT be handled or transported by transportation staff without this completed form. Upon arrival to facility, the medication(s) will be handed directly from the transportation staff to the appropriate nurse or delegated staff. Any discrepancies will be immediately followed up by the appropriate nurse.**

