Monroe County Intermediate School District

**Medication Form**

**Circle one:**

Returning Medication Receiving Medication

Name of Student Grade:

Teacher School

Delivery made to: Mother Father Classroom\_\_\_\_\_\_\_

Date Returned/Received

Medication Dose Quantity Exp. Date

Medication Dose Quantity Exp. Date

Medication Dose Quantity Exp. Date

Medication Dose Quantity Exp. Date

Date reviewed

The medication and dose match the medical care plan.

Name Date

A copy of the current plan is in blue lock bag.

Name Date

Information verified by

Teacher

 *Signature*

Staff Member

 *Signature*