

Sample Receipt for Return of Medication to Parent/Guardian

RECEIPT FOR RETURN OF MEDICATION	
Student Name: _____	DOB: _____
Teacher: _____	Grade: _____
Name of Medication: _____	Dosage: _____
Number of Pills Returned (for controlled substances only): _____	
School Nurse Signature: _____	Date: _____
Parent / Guardian Signature: _____	Date: _____

RECEIPT FOR RETURN OF MEDICATION	
Student Name: _____	DOB: _____
Teacher: _____	Grade: _____
Name of Medication: _____	Dosage: _____
Number of Pills Returned (for controlled substances only): _____	
School Nurse Signature: _____	Date: _____
Parent / Guardian Signature: _____	Date: _____

RECEIPT FOR RETURN OF MEDICATION	
Student Name: _____	DOB: _____
Teacher: _____	Grade: _____
Name of Medication: _____	Dosage: _____
Number of Pills Returned (for controlled substances only): _____	
School Nurse Signature: _____	Date: _____
Parent / Guardian Signature: _____	Date: _____