**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: