WINTON SCHOOL DISTRICT
MEDICATION VERIFICATION RECORD
SCHOOL ______________________________

Pupils Name ________________________________ DOB ________________________________ ID# _______________________

Informed Consent Received ___________________________

Teacher:
Nurse:
Code: N__________

Secretaries Name: (PRINT) CODE
1.________________________ C_______
2.________________________ C_______
3.________________________ C_______
4.________________________ C_______

SCHOOL YEAR________________

Medication returned to parent:

Date:_________ Signature ________________

Medication Destroyed:

Date: ______________ RN_______________

Witness:______________________________

Initials Medication Received
______1. Date _______Medication__________
Pills# ______Dosage:____________
______2. Date _______Medication__________
Pills# ______Dosage:____________
______3. Date _______Medication__________
Pills# ______Dosage:____________
______4. Date _______Medication__________
Pills# ______Dosage:____________
______5. Date _______Medication__________
Pills# ______Dosage:____________

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
July																															
August																															
September																															
October																															
November																															
December																															

Created: 08/16/2007 MC

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February																															
March																															
April																															
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