Valley School District No. 070
3030 Huffman Road • Valley, WA 99181 • Ph: (509) 937-2791 • Fax: (509) 937-2204 • www.valleysd.org

Receipt for Medication

Complete the following information. File original in student health file and provide a copy to the parent/guardian.

Student/Child Name:_____School: _____

Parent/Guardian Name:_____

Address: _____

Medication: _____

Type/Quantity: ☐ Capsules/Tablets:_____ ☐ Liquid cc/oz.: _____

☐ Inhaler:_____ ☐ Injectable: _____

☐ Ointment:_____ ☐ Other: _____

Medication ☐ Delivered/received ☐ Picked up Labeled correctly? ☐ Yes ☐ No

Refrigeration required? ☐ Yes ☐ No

By:

Parent/Guardian: _____ Date:_____

Signature

By:

School Employee:_____ Date:_____

Name / Signature

School Nurse: _____ Date:_____

Name / Signature

FOR OFFICE USE ONLY: *Parent/guardian was notified to pick up medication on* _____ *and has not done so after 60 days. Medication was destroyed via* _____

*Staff name / signature / date:*_____

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