

Controlled Substances Medication Count Verification Form

Refer to the Medication/Treatment Form for treatment instructions and other details. Use a new count form for each weekly supply provided by the Parent/Guardian. Attach this document to the Medication/Treatment form.

Child's name:		Name of medication:	
Parent/Guardian name:	Phone:	Today's date:	Amount (count) of medication left at site:

Please leave only enough medication for ONE WEEK.

Staff signature	Date	Time	Beginning amount	Amount given	Remaining amount

MedicationCountVerificationForm_CD
2014_06_MHAS

Communicable Disease Outreach Program

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