

**PARKWAY HEALTH SERVICES  
Medication Communication**

**Parent/Guardian completes this section:**

Student's name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Strength of Medication: \_\_\_\_\_

Number of tablets/amount of medication (ml) in bottle: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**School nurse completes this section:**

Number of tablets/amount of medication (ml) received: \_\_\_\_\_

Number of tablets/ amount of medication (ml) returned home: \_\_\_\_\_

Number of tablets/amount of medication (ml) discarded: \_\_\_\_\_

\_\_\_\_\_  
School Nurse Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature (for discarded medication)

\_\_\_\_\_  
Date