PARKWAY HEALTH SERVICES
Medication Communication

Parent/Guardian completes this section:

Student's name:_____

Name of Medication:_____

Strength of Medication:_____

Number of tablets in bottle:_____

_____

Parent/Guardian Signature Date

School nurse completes this section:

Number of tablets received:_____

_____

School Nurse Signature Date

Number of tablets returned home:_____

_____

School Nurse Signature Date