DICKINSON PUBLIC SCHOOLS

RECORD OF SUPERVISED MEDICATION/TREATMENT

Use one form for each medication received.

Student _____ Grade _____ Page _____

Log of Medication/Supplies Received:

Date	Name of Med & Dose/Items(s)	# Received	Verifying Signature (Adult)	Verifying Signature (Adult)

RECORD OF SUPERVISED MEDICATION/TREATMENT (Place Initials and Time in Box)

Name of Med/Treatment	Monday	Tuesday	Wednesday	Thursday	Friday
	04/06 No School	**04/07**	**04/08**	**04/09**	**04/10**
	04/13	**04/14**	**04/15**	**04/16**	**04/17**
	04/20	**04/21**	**04/22**	**04/23**	**04/24**
	04/27	**04/28**	**04/29**	**04/30**	**05/01**
	05/04	**05/05**	**05/06**	**05/07**	**05/08**
	05/11	**05/12**	**05/13**	**05/14**	**05/15**
	05/18	**05/19**	**05/20**	**05/21**	**05/22**
	05/25	**05/26**	**05/27**	**05/28**	**05/29**
	06/01	**06/02**	**06/03**		

Initial Identification / Full Signature

Initial	Signature	Initial	Signature	Initial	Signature