

*St. Peter RC School*  
140 N 6th St, Lewiston, NY 14092  
Main Number (716) 754-4470 • FAX (716) 754-0167

**RECEIPT OF MEDICATION DELIVERED TO SCHOOL**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Teacher/HR: \_\_\_\_\_ Grade: \_\_\_\_\_  
School Year: \_\_\_\_\_

**INITIAL MEDICATION DELIVERY**

Name of Medication: \_\_\_\_\_  
Date: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time to be given: \_\_\_\_\_  
Expiration of item(s): \_\_\_\_\_

Healthcare Provider Order Received       Parent/Guardian Permission Received

Number of Pills Received or List of What was Received: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_

**MEDICATION PICK-UP**

Date: \_\_\_\_\_ Medications: \_\_\_\_\_  
Parent Signature: \_\_\_\_\_

**SUBSEQUENT MEDICATION DELIVERY**

Date: \_\_\_\_\_  
Number of Pills Received or List of What was Received: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
Number of Pills Received or List of What was Received: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
Number of Pills Received or List of What was Received: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
Number of Pills Received or List of What was Received: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_

## SUBSEQUENT MEDICATION DELIVERY

Date: \_\_\_\_\_  
Number of Pills Received or List of What was Received: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
Number of Pills Received or List of What was Received: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
Number of Pills Received or List of What was Received: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_

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Number of Pills Received or List of What was Received: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_  
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School Nurse Signature: \_\_\_\_\_  
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Number of Pills Received or List of What was Received: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
Number of Pills Received or List of What was Received: \_\_\_\_\_  
School Nurse Signature: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_

END