COLLINS-MAXWELL
SPARTANS

Controlled Medication Check In/Check Out

Student Name:	DOB:
Parent Name:	Phone:
Medication:	Dose:
○ Picked Up ○ Dropped Off	Number of pills:
I certify that I have picked up or dropped off the controlled medication listed for the student above, and that I am the student's parent/guardian.	
Signature of Parent:	Date:
Signature of School Representative:	Date: