SNOHOMISH HEALTH DISTRICT
WWW.SNOHD.ORG

Controlled Substances Medication Count Verification Form

Refer to the Medication/Treatment Form for treatment instructions and other details. Use a new count form for each weekly supply provided by the Parent/Guardian. Attach this document to the Medication/Treatment form.

Child's name:		Name of medication:	
Parent/Guardian name:	Phone:	Today's date:	Amount (count) of medication left at site:

Please leave only enough medication for ONE WEEK.

Staff signature	*Date*	*Time*	*Beginning amount*	*Amount given*	*Remaining amount*

MedicationCountVerificationForm
2017_10_BD