OASIS CHARTER SCHOOLS
CITY OF CAPE CORAL

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Medication **CHECK-IN**

Student Name: _____ DOB: _____ Grade: _____

Medication Name: _____

Quantity: _____

Medication Expiration Date: _____

Clinic Staff Name: _____

Clinic Staff Signature: _____ Date: _____

Parent/Guardian: By signing this I agree that I have verified the medication and quantity of the medication being checked **IN** with the clinic staff and I agree the stated information is accurate.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone # for quickest response: _____

Medication **CHECK-OUT**

Medication Name: _____

Quantity: _____

Clinic Staff Name: _____

Clinic Staff Signature: _____ Date: _____

Parent/Guardian: By signing this I agree that I have verified the medication and quantity of the medication being checked **OUT** with the clinic staff and I agree the stated information is accurate.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Clinic Notes:_____

_____

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