Public Health
Seattle & King County

Controlled Substance Medication Form

Early Learning Program Name: _____

Child's Name:	**Reason for Medication/Diagnosis:**
Name of Medication:	**Requires Refrigeration:** ☐ **Yes** ☐ **No**
Medication Start Date: ____/____/____	**Medication Stop Date:** ____/____/____
Date Received: ____/____/____	**Date Returned:** ____/____/____
Amount Received at Program: **Director Signature:** (acknowledging amount left at program)	**Amount Returned to Parent/Guardian:** **Parent/Guardian Signature:** (acknowledging amount returned)

Child has a 3-day emergency supply of medication at center/school:

☐**Yes** (complete and attach 3-Day Critical Medication Form) ☐ **N/A**

DATE	TIME	STARTING AMOUNT/ QUANTITY	AMOUNT/ QUANTITY GIVEN	Staff 1 Initials (person giving medication)	Staff 2 Initials (person witnessing medication given)

Staff 1 Signature_____ Print Name _____

Staff 2 Signature_____ Print Name _____

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