

Derry Cooperative School District  
Medication Drop Off / Received Form

Student's Name: \_\_\_\_\_

Teacher or Team: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Medication: \_\_\_\_\_

Amount Received: \_\_\_\_\_

Received From (Signature): \_\_\_\_\_

Person Receiving Medication  
(Signature): \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_