NYC Department of Health and Mental Hygiene | Department of Education

Office of School Health

CONTROL SUBSTANCE COUNT SHEET

Student Name: ____ DOB: ____/____/____

Name of Medication: ______________________ Dosage: _________ Route: _______ Frequency: ____________

Date	Time	AMT:	On Hand	Used	Remaining	Staff Signature	Witness
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________
__/__/__	____:____am/pm	#	_____	_____	_____	____________________	___________________

*Control Substance Count Sheet should be completed daily