Prince George's County Public Schools
Office of Health Services
Medication Inventory for Controlled Drugs

Name of Student: _____ (DOB: _____) School: _____ School Year: _____

Medication/Dosage: _____ (Only One Medication per Form)

Date	Time	New amount Received	Plus +	Previous Actual Balance	Total	Minus -	Amount Given	Amount Wasted	Amount Returned to Guardian	Expected Balance	Actual Balance	Correct-C *Error-E	Initials	Remarks
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								

NOTE An E in the "Correct-Error Column" requires that a Medication Error Incident Report be completed. This form MUST be completed in RED ink.

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			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								
			+			–								

Signature(s) of Medication Administrators	Position	Initials

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