Controlled Monthly Count Sheet

Name of Person: _____ Name of Medication: _____

Dosage of Drug per Prescription Label: _____ Month: _____ Year: _____

*Please submit to PDPMAR@iamboundless.org when document is completed at the end of each month.

*Please only use **one** count sheet per controlled medicine, do not combine them in one form.

Date	Time	Quantity Available	Quantity Given	Quantity Remaining	Staff Signature or NS for Natural Support

Staff Name (Printed): _____ Staff Signature: _____

Staff Name (Printed): _____ Staff Signature: _____

Staff Name (Printed): _____ Staff Signature: _____

Staff Name (Printed): _____ Staff Signature: _____

Staff Name (Printed): _____ Staff Signature: _____