

**Mississippi Department of Human Services
 Division of Youth Services
 Medical Services
 Oakley**

SUPPLY CONTROL FORM

Product Description: _____

Lot Number: _____ **Expiration Date:** _____ **Package Size:** _____

Health Care Personnel Completing Form: _____ **Date:** _____

Date	Balance	Amount Removed from Stock	Amount Added to Stock	Balance	Comments	Nurse's Signature

Reviewed by Director of Medical Services: _____
Signature Date