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

SUPPLY CONTROL MONITORING FORM

Supply Item Name	Actual # Present	Actual # Recorded	Discrepancy/Comments

Health Care Personnel Completing Monitoring Form: _____

Date: _____ **Time:** _____ **Accountability accurate:** ☐ **Yes** ☐ **No**

Reviewed by Health Service Supervisor: _____

Signature Date