



AUTHORIZATION FOR DISPOSITION OF UNUSED MEDICATION

This section to be completed by the Health Office:

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

Medication(s) stored at school (prescription and non-prescription): _____

School Nurse: _____ Phone #: _____ Date: _____

This section to be completed by the parent:

If there is any unused medication, please:

- Discard any remaining medication.
- Keep medication at school for summer school.
- I will pick up medication on or before the last day of student attendance.

If this form is not complete and returned to the Health Office on or before the last day of student attendance, all medication (prescription and non-prescription) will be disposed of according to the WI Department of Natural Resources.

If you have questions, please contact the school nurse.

Parent/Guardian Signature: _____ Date: _____

FOR HEALTH OFFICE USE ONLY

Date: _____

Disposition form received. Quantity/Amount of medication returned to parent/guardian: _____

No Disposition form received. Quantity/Amount of medication abandoned: _____

Disposition Location: _____ Witness #1 Signature: _____ Witness #2 Signature: _____