SHELBY COUNTY SCHOOLS
Health Services
Medication Disposal Form

Please use a separate sheet for each medication.
Print the name of the medication as written on the pharmacy label or printed on the over-the-counter bottle.

School: ____ School Year: _______________________

Student Name: ____________________________ Medication Name: ______________________________

Dose: _______ Doses prepared for risk management pick up: __________(#) Date: ________________

Risk Management contacted by: ____ Date: _________
If medication not picked up by Risk Management prior to the last day of school notify Health Services at 416-2425

Was parent notified to pick up medication? ☐ Yes ☐ No
If yes, number of contacts or attempts that were made _______ ☐Phone ☐Letter ☐In person
Attempts made by (print name): ____

Please check the type of medication to be disposed of:

☐**Inhaler**	☐**Pills/Tablets/Capsules**
☐**Epi-Pen**	☐**Topical**
☐**Diastat**	☐**Liquid**
☐**Insulin vial**	☐**Eye Drops/Ointment**
☐**Insulin pen**	☐ **Ear Medication**
☐**Solu Cortef**	☐**Other** _______________________________________

Comments:____

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