St. Croix Central School District

AUTHORIZATION FOR DISPOSITION OF UNUSED MEDICATION

This section to be completed by Health Office:

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

Medication(s) stored at school:

_____

_____

_____

School Nurse/Health Assistant: _____ 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 school

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/health assistant.

Parent/Guardian Signature: _____ Date:_____