DISPOSAL OF MEDICATION

(All discontinued prescription medication must be taken to a pharmacy for disposal)

NAME OF CLIENT: _____

NAME OF MEDICATION DISPOSED: _____

DOSAGE: _____

NAME OF PHARMACY WHERE DISPOSED: _____

ADDRESS OF PHARMACY: _____

DATE & TIME OF DISPOSAL: _____

AMOUNT DISPOSED: _____

SIGNATURE OF PHARMACIST DISPOSING OF THE MEDICATION: _____

SIGNATURE OF STAFF DISPOSING OF THE MEDICATION: _____

DATE: _____