Tennessee Department of Children's Services

# Medication Disposal Record

**Facility Name:** _____

| Date | Rx# | Student Name | Medication/Dose | # or Amt | Reason | Means | Staff Signature | Rph/Witness Signature |
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*Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.*
*Distribution:* YDC Health Clinic or Residential Facility Record