Department of Catholic Schools
Diocese of Wheeling-Charleston

Form 5910.4

SCHOOL NAME:_____

STUDENT NAME: _____

MEDICATION
Receipt/Return/Disposal

Date	Name of Medication	Received *Amount*	Returned *Amount*	Disposed of *Amount*	Signature of school personnel receiving, returning or disposing of medication.	Signature of parent/guardian delivering to school or picking up unused medication.