Consent to Return
Unwanted or Discontinued Medication

Young Person's Name	
Parent/Guardian Name	

I authorise that the following medicines can be taken to the pharmacy/GP dispensing practice, for destruction if no longer required, discontinued or expired.

Name, strength & form of medicine	Quantity

Parent/Guardian Signature: ________________________________ Date: ____________

Name of staff member returning Medication: ________________________

Signature of staff member: ________________________________ Date: ____________

For Pharmacy Use Only		
Name of Pharmacist:		
I confirm that the medicines listed above have been handed over for destruction		
Signature:		Date:
Address/stamp		

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