



**Brecksville-
Broadview Heights
City School District**

Brecksville-Broadview Heights City Schools
Board of Education Office

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BRECKVILLE-BROADVIEW HEIGHTS CITY SCHOOL DISTRICT PRESCRIPTION MEDICATION AUTHORIZATION

NAME _____ BIRTH DATE _____ SCHOOL _____
TEACHER _____ GRADE _____
ADDRESS _____

To the Parent/Guardian:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO RECEIVES OR USES PRESCRIBED MEDICATIONS IN SCHOOL; BOTH PORTIONS OF THIS FORM MUST BE COMPLETED.

1. I am requesting permission for the student named above to receive or use medication according to the doctor's verification on this form. I have instructed my child to report to the school office to receive the medication at the designated time. I will keep an adequate supply of medication at school.
2. I will assume responsibility for safe delivery of the medication to the school office by myself or call the principal to make other arrangements.
3. I will call the school office and send a written note if my child is taken off this medication. I will retrieve the medication within three (3) days.

Signature of Parent/Guardian

Date

Day phone _____ Cell phone _____

**ALL MEDICATION MUST BE IN ORIGINAL PHARMACY DISPENSED CONTAINERS.
LABELS MUST MATCH INSTRUCTIONS FROM DOCTOR ON THIS FORM.**

PHYSICIAN STATEMENT

To the Physician:

Brecksville-Broadview Heights City School District encourages you to schedule medications at times outside of school hours. When that is not possible, the medication listed below will be dispensed during school hours. Medication in pill form is preferable to liquids for use in school.

I verify that this medication must be taken by _____ (student)

Medication

Dosage

Route

Diagnosis for which medication is prescribed _____

Medication is to be taken at the following times _____

Instructions or precautions (Including possible side effects) _____

Prescription beginning date _____ Prescription expiration date _____

Date form completed _____ Physician Signature _____

Physician Printed Name _____ Phone Number _____

Physician Address _____

NAME _____

Medication

Dosage

How Often

Time

[illegible]

Initials_____ Signature_____

Initials_____ Signature_____

Initials _____ Signature _____

Initials _____ Signature _____

Initials _____ Signature _____

Initials _____ Signature _____