

**BRECKVILLE-BROADVIEW HEIGHTS CITY SCHOOL DISTRICT  
PRESCRIPTION MEDICATION AUTHORIZATION**

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

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.**

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**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

Date Given	Hour Given	Initials	Date Given	Hour Given	Initials	Date Given	Hour Given	Initials

Initials \_\_\_\_\_ Signature \_\_\_\_\_  
Initials \_\_\_\_\_ Signature \_\_\_\_\_  
Initials \_\_\_\_\_ Signature \_\_\_\_\_  
Initials \_\_\_\_\_ Signature \_\_\_\_\_  
Initials \_\_\_\_\_ Signature \_\_\_\_\_