Date: [Date]

To: [School Name] Administration and School Nurse

Address: [School Address]

RE: Authorization for Administration of Prescription Medication

Student Name: [Student Full Name]
Date of Birth: [Date of Birth]
Grade/Class: [Grade Level]

To whom it may concern,

I, [Parent/Guardian Name], hereby authorize the designated school personnel at [School Name] to administer the following prescription medication to my child during school hours.

Medication Details:

- **Medication Name:** [Name of Medication]
- **Dosage:** [e.g., 5mg, 1 tablet]
- **Route of Administration:** [e.g., Oral, Inhaler, Injection]
- **Time/Frequency:** [e.g., Once daily at 12:00 PM]
- **Reason for Medication:** [Diagnosis/Condition]
- **Start Date:** [Date]
- **End Date:** [Date or End of School Year]

Physician Information:

Name: [Physician Name]
Phone Number: [Physician Phone Number]

I understand that I must provide the medication in its original pharmacy-labeled container. I also agree to notify the school immediately of any changes to the medication or dosage.

Sincerely,

_____
Parent/Guardian Signature

Parent/Guardian Phone: [Phone Number]

Physician Authorization (If required by school policy):

I confirm that the above-named student requires this medication during school hours as prescribed.

_____

Physician Signature and Stamp