Date: [Date]

To: [School Name / School Nurse]
From: [Physician Name/Clinic Name]
Subject: Return to School and Medication Administration Authorization

Patient Name: [Patient Name]
Date of Birth: [Date of Birth]

To Whom It May Concern,

The above-named patient was seen at our clinic on [Date of Visit].

Return to School:
The patient is cleared to return to school on [Return Date].

Activity Restrictions:
[ ] No restrictions.
[ ] The following restrictions apply: [List restrictions, e.g., no PE, no recess] until [End Date].

Medication Administration:
The patient requires the following medication(s) to be administered during school hours:

- **Medication Name:** [Medication Name]
- **Dosage:** [e.g., 5mg or 2 puffs]
- **Route:** [e.g., Oral, Inhaled]
- **Time/Frequency:** [e.g., 12:00 PM or As needed every 4 hours]
- **Indication:** [e.g., For asthma, For pain]
- **Duration:** [e.g., 5 days or Entire school year]

Special Instructions:
[Enter any specific storage instructions or side effects to watch for]

I authorize the school nurse or designated school personnel to administer the medication listed above as prescribed.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Phone Number]
[Clinic Stamp]

Parent/Guardian Consent:
I give permission for my child to receive the medication listed above at school.

[Parent/Guardian Signature]
[Date]