Date: [Date]

To: [School Name] Health Services
Attn: School Nurse / Administration

RE: Physician Authorization for Medication Administration

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

To whom it may concern,

I am the prescribing physician for the student named above. This letter serves as formal authorization for the school nurse or designated school personnel to administer the following medication(s) to this student during school hours.

Medication Name: [Name of Medication]
Dosage: [Amount to be given, e.g., 5mg]
Route: [e.g., Oral, Inhaled, Topical]
Frequency/Time: [e.g., Once daily at 12:00 PM]
Reason for Medication: [Diagnosis or Condition]
Side Effects to Watch For: [List common side effects]

Special Instructions: [e.g., Take with food, PRN/As needed instructions, Storage requirements]

Effective Dates: From [Start Date] to [End Date/End of School Year]

I confirm that this student is capable of and has been instructed on how to self-administer this medication: [Yes / No / Not Applicable]

If there are any questions regarding this medical order, please contact my office at [Physician Phone Number].

Sincerely,

[Physician Signature]

Physician Name: [Printed Name]
Medical License #: [License Number]
Clinic Name: [Clinic/Hospital Name]
Phone: [Phone Number]
Fax: [Fax Number]