Date: [Insert Date]

To: [Parent/Guardian Name]
From: [School Name/Health Office]
Subject: Medication Administration and Return to School Requirements

Dear [Parent/Guardian Name],

This letter is to confirm the requirements for your child, [Student Name], to receive medication at school and the conditions for their return to classes following an illness.

Medication Administration:

- All medications (prescription and over-the-counter) must be delivered to the school office by an adult in the original pharmacy container.
- A signed "Medication Authorization Form" must be completed by both the parent and the licensed healthcare provider.
- The label must clearly state the student's name, dosage, time of administration, and expiration date.

Return to School Guidelines:

To ensure the health and safety of all students, your child may return to school only when the following criteria are met:

- The student has been fever-free for at least 24 hours without the use of fever-reducing medication.
- The student has not experienced vomiting or diarrhea for at least 24 hours.
- If prescribed antibiotics, the student must have completed the first 24 hours of the dosage.
- The student is well enough to participate in normal school activities.

If you have any questions regarding these policies, please contact the school health office at [Phone Number].

Sincerely,

[Signature]
[Name of School Nurse/Administrator]
[Title]