Date: [Date]

To: School Administration / School Nurse
School Name: [Name of School]
Address: [School Address]

Subject: Authorization for Medication Administration

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

To Whom It May Concern,

I, [Parent/Guardian Name], hereby authorize the school nurse or designated school personnel to administer the following medication to my child during school hours:

- **Medication Name:** [Name of Medication]
- **Dosage:** [e.g., 5mg, 1 tablet, 2 puffs]
- **Time of Administration:** [e.g., 12:00 PM or As Needed]
- **Route:** [e.g., Oral, Inhaler, Topical]
- **Reason for Medication:** [e.g., Asthma, Allergy, ADHD]
- **Start Date:** [Date]
- **End Date:** [Date or End of School Year]

I understand that I must provide the medication in its original pharmacy container, clearly labeled with the student's name, medication name, dosage, and prescribing doctor's instructions.

In case of any adverse reaction or emergency, please contact me immediately at the number(s) listed below.

Parent/Guardian Signature: _____

Phone Number: [Your Phone Number]
Emergency Contact: [Name and Number of Secondary Contact]

Physician's Authorization (If Required by School):

I confirm that the above medication is necessary for this student during school hours.

Physician Name: [Doctor's Name]
Physician Signature: _____
Clinic Phone: [Clinic Phone Number]