Date: [Date]

To: [School Name] Health Services

Re: Medical Clearance and Medication Authorization for [Student Full Name]

Date of Birth: [Student Date of Birth]

To Whom It May Concern,

I am writing to confirm that [Student Name] is under my medical care and is cleared to participate in school activities, including [Physical Education/Sports/General Classroom Activities].

The student requires the administration of the following medication(s) during school hours:

- **Medication Name:** [Medication Name]
- **Dosage:** [e.g., 5mg or 2 puffs]
- **Route:** [e.g., Oral, Inhaled, Topical]
- **Time/Frequency:** [e.g., Daily at 12:00 PM or As needed every 4 hours]
- **Diagnosis/Reason for Medication:** [Reason]
- **Special Instructions/Side Effects:** [Instructions]

Self-Administration (Check one):
[ ] The student is capable of self-administering this medication.
[ ] The student requires school personnel to administer this medication.

This authorization is valid for the duration of the [Year] school year unless otherwise revoked in writing.

If you have any questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

Physician Name: [Name and Credentials]
Medical License #: [License Number]
Clinic/Practice Name: [Name]