Date: [Date]

To: [School Principal/School Nurse Name]
[School Name]
[School Address]

RE: Authorization for Prescription Medication Administration

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

Dear [Recipient Name],

I am writing to request that school personnel assist my child with the administration of the following prescription medication upon their return to school on [Return Date].

Medication Details:
Medication Name: [Name of Medication]
Dosage: [e.g., 5mg]
Route: [e.g., Oral/Inhaler]
Time(s) of Administration: [e.g., 12:00 PM]
Reason for Medication: [Optional - e.g., Infection/Chronic Condition]

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

I have attached the required medical authorization form signed by our healthcare provider [Name of Doctor].

Please contact me at [Phone Number] or [Email Address] if you have any questions regarding this request.

Sincerely,

[Parent/Guardian Signature]
[Parent/Guardian Printed Name]