Date: [Insert Date]

To: [School Name / School Nurse Name]
From: [Healthcare Provider Name/Clinic]
Subject: Medication Authorization and School Re-Entry

Student Name: [Student Full Name]
Date of Birth: [Student DOB]

To Whom It May Concern,

This letter serves to authorize the return of the above-named student to school on [Return Date]. The student has been under my care for a non-contagious/resolved condition and is cleared to resume all regular school activities.

The student requires the administration of the following short-term medication during school hours:

- **Medication Name:** [Name of Medication]
- **Dosage:** [e.g., 250mg / 1 tablet]
- **Route:** [e.g., Oral]
- **Time/Frequency:** [e.g., Once daily at 12:00 PM]
- **Duration:** [Start Date] to [End Date]
- **Reason for Medication:** [Diagnosis/Indication]

**Special Instructions:** [e.g., Take with food, monitor for drowsiness, or N/A]

I confirm that the student is stable enough to be at school. Please contact my office at [Phone Number] if there are any questions regarding these instructions.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]
[Clinic Stamp/Address]

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**Parent/Guardian Consent:**

I hereby give permission for school personnel to administer the medication as prescribed above.

Parent Name: _____ Signature: _____ Date: _____