Date: [Insert Date]

To: [Recipient Name/Organization Name]
Department: [e.g., School Office / Nursing Department]
Address: [Insert Address]

Subject: Medication Administration Authorization for [Patient/Student Name]

Dear [Recipient Name or Title],

I, [Your Full Name], am the [Parent/Legal Guardian/Patient] of [Patient Name, Date of Birth]. I hereby authorize the designated staff or medical personnel at [Organization Name] to administer the following medication(s) as prescribed by our healthcare provider.

Medication Details:

- **Medication Name:** [Insert Name]
- **Dosage:** [Insert Amount, e.g., 5mg]
- **Route:** [e.g., Oral, Topical, Injection]
- **Time/Frequency:** [e.g., Once daily at 12:00 PM]
- **Purpose:** [e.g., Allergy management]
- **Duration:** [Start Date] to [End Date]

Special Instructions/Side Effects:
[Insert any specific instructions or known side effects to watch for]

Prescribing Physician Information:
Name: [Doctor Name]
Phone Number: [Doctor Phone Number]

I confirm that the medication is in its original container and is clearly labeled with the patient's name and dosage instructions. I release [Organization Name] and its employees from any liability regarding the administration of this medication as instructed.

In case of an emergency, please contact me immediately at [Your Phone Number].

Sincerely,

[Your Signature]

[Your Printed Name]
[Your Relationship to Patient]