Date: [Date]

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

RE: Authorization for Administration of Prescription Medication

Student Name: [Student Full Name]
Date of Birth: [Student Date of Birth]
Grade/Room: [Grade/Classroom Number]

To the School Nurse,

I am writing to authorize the administration of the following prescription medication to my child during school hours.

Medication Information:

- Name of Medication: [Medication Name]
- Dosage: [e.g., 5mg, 1 tablet]
- Route: [e.g., Oral, Inhaled, Topical]
- Time(s) of Administration: [e.g., 12:00 PM or As Needed for specific symptoms]
- Reason for Medication: [Diagnosis/Condition]
- Possible Side Effects: [List side effects]
- Duration of Order: [Start Date] to [End Date]

I confirm that this medication is in its original pharmacy container, labeled with the student's name, medication name, dosage, and prescribing doctor's instructions.

Prescribing Physician Information:

Physician Name: [Doctor's Name]
Phone Number: [Doctor's Phone Number]

Parent/Guardian Consent:

I give permission for the school nurse or designated school personnel to administer this medication as prescribed. I also give permission for the school nurse to contact the prescribing physician regarding this medication if necessary.

Parent/Guardian Signature: _____

Parent/Guardian Print Name: [Your Name]

Primary Phone Number: [Your Phone Number]

Emergency Contact: [Name and Phone Number]