Date: [Insert Date]

To: [Insert Parent/Guardian Name or School/Organization Name]

Subject: Approval for Over-the-Counter (OTC) Medication Administration

Dear [Insert Name],

This letter serves as formal authorization for **[Insert Patient Name]** (Date of Birth: [Insert DOB]) to receive certain over-the-counter medications as deemed necessary by the clinic staff.

The following medications are approved for administration according to the manufacturer's recommended dosage for age and weight:

- Acetaminophen (Tylenol) - For pain or fever
- Ibuprofen (Advil/Motrin) - For pain or inflammation
- Diphenhydramine (Benadryl) - For allergic reactions
- Calcium Carbonate (Tums) - For indigestion
- Antibiotic Ointment (Neosporin) - For minor cuts/scrapes
- Hydrocortisone Cream - For minor skin irritations

Special Instructions/Allergies: [Insert any allergies or "None"]

This approval is valid from **[Insert Start Date]** to **[Insert End Date]**.

Should the patient require medication beyond these parameters, or if symptoms persist, the clinic will contact the primary healthcare provider or legal guardian immediately.

Sincerely,

[Signature]
[Insert Name of Healthcare Provider]
[Insert Title/Credentials]
[Insert Clinic Name]
[Insert Phone Number]