Date: [Date]

To: [School Nurse Name]
[School Name]

Re: Medication Administration for [Student Full Name]
Date of Birth: [Student Date of Birth]

Dear School Nurse,

This letter is to request and authorize the administration of psychiatric medication for my child, [Student Name], during school hours.

Medication Details:

- **Medication Name:** [Name of Medication]
- **Dosage:** [e.g., 10mg]
- **Route:** [e.g., Oral tablet]
- **Time of Administration:** [e.g., 12:00 PM]
- **Diagnosis/Reason for Medication:** [e.g., ADHD, Anxiety]

Special Instructions:
[Insert instructions, e.g., Take with food, or "None"]

Potential Side Effects:
[List common side effects to watch for]

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

I have provided the medication in its original pharmacy container, labeled with the student's name and dosage instructions. Please contact me if there are any changes in the student's behavior or if a dose is missed.

Sincerely,

[Parent/Guardian Signature]

[Parent/Guardian Printed Name]
[Phone Number]