Date: [Insert Date]

To: [Clinic or School Name]
Attn: Health Office / Nursing Staff
Address: [Insert Address]

RE: Temporary Authorization for Administration of Oral Medication

To whom it may concern,

I, [Parent/Guardian Name], hereby authorize the staff at [Clinic/School Name] to administer the following oral medication to my child, [Child's Full Name], born on [Child's Date of Birth].

Medication Details:
Medication Name: [Insert Name]
Dosage: [Insert Amount, e.g., 5mg or 1 Tablet]
Route: Oral
Time/Frequency: [Insert Time, e.g., 12:00 PM or Every 4 hours]
Reason for Medication: [Insert Reason]

Authorization Period:
Start Date: [Insert Date]
End Date: [Insert Date]

I confirm that the medication is provided in its original pharmacy container, clearly labeled with my child's name and dosage instructions. I understand that I am responsible for notifying the facility of any changes to this prescription.

In case of any adverse reactions or questions, please contact me immediately at [Your Phone Number].

Sincerely,

[Signature]
[Printed Name]
[Relationship to Child]