

Date: [Insert Date]

To: [Insert Name of School, Daycare, or Facility]

Attention: [Insert Contact Person/Nurse Name]

RE: Medication Authorization for [Patient Full Name]

Date of Birth: [Insert Date of Birth]

Current Weight: [Insert Weight] [kg/lbs] as of [Insert Date]

To Whom It May Concern,

I am the primary care provider for the above-named patient. I am providing authorization for the administration of the following medication(s) based on the patient's current weight:

Medication Name: [Insert Name, e.g., Acetaminophen/Ibuprofen]

Concentration: [Insert Concentration, e.g., 160mg/5mL]

Calculated Dosage: [Insert Dose, e.g., 5mL or 160mg]

Route: [e.g., Oral]

Frequency: Every [Number] hours as needed for [Indication, e.g., Fever or Pain]

Maximum Dose: [Insert Maximum Doses per 24 hours]

Please update the patient's records to reflect this weight-based calculation. This authorization is valid until [Insert Expiration Date] or until the patient's weight changes significantly.

If there are any questions regarding these instructions, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Clinic/Practice Name]

[Medical License Number]