

Date: [Insert Date]

To: [School Name] Administration / School Nurse

Subject: Authorization for Weight-Based Medication Administration

Student Name: [Student Full Name]

Date of Birth: [MM/DD/YYYY]

Current Weight: [Insert Weight] [kg/lbs]

Weight Recorded Date: [Insert Date]

To whom it may concern,

I hereby authorize the school nurse or designated school personnel to administer the following medication to my child according to the weight-based dosage prescribed below:

- **Medication Name:** [Insert Medication Name]
- **Indication:** [e.g., Fever, Allergic Reaction, Pain]
- **Dosage Calculation:** [Insert mg per kg/lb]
- **Total Dose to Administer:** [Insert Amount, e.g., 5ml or 250mg]
- **Route of Administration:** [e.g., Oral, Topical]
- **Frequency/Time:** [e.g., Every 6 hours as needed]

Physician Information:

Name: [Physician Name]

Phone Number: [Physician Phone Number]

Clinic Name: [Clinic Name]

I understand that it is my responsibility to notify the school immediately if there is a significant change in my child's weight or a change in the prescription. I release the school and its staff from any liability regarding the administration of this medication as directed.

Sincerely,

Parent/Guardian Signature

Parent/Guardian Name: [Print Name]

Phone Number: [Insert Phone Number]

Physician Signature (if required by school):

Date: [Insert Date]