

Date: [Insert Date]

To: [Facility Name]
[Facility Address]
[City, State, Zip Code]

Subject: Authorization for Medication Administration

Patient Name: [Full Name of Resident]
Date of Birth: [Date of Birth]
Resident ID/Room Number: [Number]

To whom it may concern,

I, [Your Name], acting as the [Self/Legal Guardian/Power of Attorney], hereby authorize the licensed nursing staff and authorized personnel at [Facility Name] to administer the following medications to the above-named resident as prescribed by their healthcare provider.

This authorization includes:

- Prescription medications as listed on the current Physician's Order Sheet.
- Over-the-counter (OTC) medications as approved by the attending physician.
- Pro re nata (PRN) or "as needed" medications for specific symptoms.

Prescribing Physician Information:

Name: [Physician Name]
Phone: [Physician Phone Number]

I understand that it is my responsibility to notify the facility immediately of any changes to the resident's medical condition or changes made by an external specialist to the medication regimen.

This authorization shall remain in effect for the duration of the resident's stay at the facility unless revoked in writing.

Sincerely,

[Signature]

[Printed Name]
[Relationship to Resident]
[Phone Number]