**Date:** [Insert Date]

**To:** [School Name / Facility Name / Organization Name]
**Attention:** [Health Office / Nursing Staff / Administrator Name]

**RE: Controlled Substance Medication Administration Authorization**

**Patient/Student Name:** [Full Name]
**Date of Birth:** [Date of Birth]

I, [Parent/Guardian or Prescribing Physician Name], hereby authorize the designated and trained personnel at [Facility Name] to administer the following controlled substance medication to the above-named individual:

- **Medication Name:** [Name of Medication]
- **Dosage:** [Strength/Amount, e.g., 10mg]
- **Route:** [e.g., Oral, Topical]
- **Frequency/Time of Administration:** [e.g., Daily at 12:00 PM]
- **Diagnosis/Reason for Medication:** [Reason for Prescription]
- **Start Date:** [Date]
- **End Date:** [Date or "End of Term"]

**Potential Side Effects:** [List side effects or "See attached prescribing information"]

**Emergency Procedures:** [Instructions if a reaction occurs]

**Physician Information:**
Name: [Physician Name]
Phone Number: [Phone Number]
Clinic/Hospital: [Name of Practice]

**Prescribing Physician Signature: _____ Date: _____**

**Parent/Guardian Consent:**
I give permission for the staff to administer this medication as prescribed. I understand that I am responsible for providing the medication in its original pharmacy-labeled container and for maintaining an adequate supply.

**Parent/Guardian Signature: _____ Date: _____**

**Phone Number:** [Phone Number]