

**Date:** [Date]

**To:** [Name of School/Facility/Provider]

**Attention:** [Staff Name or Health Office]

# Authorization for Administration of As-Needed (PRN) Medication

**Patient/Student Name:** [Full Name]

**Date of Birth:** [DOB]

I hereby authorize the staff at [Name of Facility] to administer the following medication to the above-named individual on an as-needed (PRN) basis.

Medication Name	Dosage	Route (e.g., Oral)
[Name of Med]	[Amount]	[How it is taken]

**Reason for Medication:** [e.g., Headache, Allergic Reaction, Menstrual Cramps]

**Specific Indicators for Administration:** [Describe symptoms that warrant the dose]

**Frequency:** [e.g., Every 4-6 hours as needed; do not exceed X doses per day]

**Special Instructions/Precautions:** [e.g., Take with food, notify parent if symptoms persist]

**Effective Dates:** From [Start Date] to [End Date/End of School Year]

## Parent/Guardian Authorization:

I give permission for the person named above to receive this medication as directed. I understand that I am responsible for providing the medication in its original pharmacy-labeled container.

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Parent/Guardian Signature

**Phone Number:** [Phone Number]

## Physician Authorization (If Required):

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Physician Signature

**Physician Name/Clinic:** [Name and Phone Number]