

Date: [Date]

To: [Facility Name / School Name / Healthcare Provider]

Attention: [Name of Administrator or Nurse]

RE: Authorization for Administration of Psychotropic Medication

Patient/Student Name: [Full Name]

Date of Birth: [DOB]

To whom it may concern,

I, [Your Name], being the legal [Parent/Guardian/Self] of the above-named individual, hereby authorize the designated staff at [Organization Name] to administer the following psychotropic medication(s) as prescribed by [Prescribing Physician's Name].

Medication Details:

- **Medication Name:** [Name of Medication]
- **Dosage:** [e.g., 10mg]
- **Frequency/Time:** [e.g., Once daily at 8:00 AM]
- **Route:** [e.g., Oral]
- **Diagnosis/Purpose:** [Reason for medication]
- **Potential Side Effects:** [List known side effects]

I confirm that the first dose of this medication was administered on [Date] and no adverse reactions were observed.

This authorization is valid from [Start Date] to [End Date/Ongoing]. I understand that I must provide the medication in its original pharmacy container, clearly labeled with the patient's name, medication name, dosage, and prescribing doctor's instructions.

In case of emergency or questions regarding this treatment, please contact:

Primary Contact: [Name] - [Phone Number]

Prescribing Physician: [Doctor Name] - [Phone Number]

Sincerely,

(Signature)

[Printed Name]

[Relationship to Patient]

[Phone Number]