

**Date:** [Insert Date]

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

**Address:** [Insert Address]

**Subject: Routine Daily Medication Administration Authorization**

To Whom It May Concern,

I, [Parent/Guardian Name], hereby authorize the staff at [Name of School/Facility] to administer the following routine medication to my child/ward, [Child's Full Name], born on [Child's Date of Birth].

**Medication Details:**

- **Medication Name:** [Insert Name]
- **Dosage:** [Insert Dose, e.g., 5mg or 1 tablet]
- **Route:** [e.g., Oral, Topical]
- **Time of Administration:** [Insert Time, e.g., 12:00 PM daily]
- **Reason for Medication:** [Insert Condition]
- **Start Date:** [Insert Date]
- **End Date:** [Insert Date or "Until further notice"]

**Special Instructions/Possible Side Effects:**

[Insert any specific instructions or known reactions]

**Prescribing Physician Information:**

Name: [Doctor's Name]

Phone: [Doctor's Phone Number]

I confirm that the medication is in its original container with the pharmacy label intact. I understand that it is my responsibility to provide the medication and to notify the facility immediately of any changes to the prescription.

In case of emergency, please contact me at [Your Phone Number].

Sincerely,

[Your Signature]

[Your Printed Name]

[Relationship to Child]