Date: [Insert Date]

To: [Insert School/Facility Name] Health Services

Annual Renewal: Medication Administration Authorization

Student/Patient Name: [Insert Full Name]
Date of Birth: [Insert Date of Birth]
Academic/Service Year: [Insert Year, e.g., 2024-2025]

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1. Medication Information

Medication Name: [Insert Medication Name]
Dosage: [Insert Dosage, e.g., 5mg]
Route: [Insert Route, e.g., Oral]
Time/Frequency: [Insert Time or Frequency]
Diagnosis/Reason for Medication: [Insert Reason]

2. Prescriber Authorization

I certify that the medication listed above is required during school/program hours. This authorization is valid for the current academic year unless otherwise notified.

Prescriber Name: [Insert Name]
Prescriber Signature: ____________________________
Phone Number: [Insert Phone]
Date: [Insert Date]

3. Parent/Guardian Consent

I hereby request and give permission for the staff of [Insert Facility Name] to administer the medication specified above to my child. I understand that I must provide the medication in its original pharmacy-labeled container.

Parent/Guardian Name: [Insert Name]
Parent/Guardian Signature: ____________________________
Emergency Contact Number: [Insert Phone]
Date: [Insert Date]

4. Special Instructions

[Insert any specific storage requirements, potential side effects, or emergency procedures here.]