Date: [Insert Date]

To: [Name of Facility/School/Organization]
From: [Name of Physician/Hospital Unit]
Subject: Post-Discharge Medication Administration Authorization

Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Date of Discharge: [Insert Date]

To Whom It May Concern,

The above-named patient was recently discharged from [Name of Hospital/Facility]. This letter serves as formal authorization for the administration of the following medications during [school hours/program hours/facility care]:

- **Medication Name:** [Insert Name]
- **Dosage:** [Insert Dosage]
- **Route:** [e.g., Oral, Topical, Inhalation]
- **Frequency/Time:** [Insert Schedule]
- **Duration:** [Start Date] to [End Date]
- **Reason for Medication:** [Insert Diagnosis/Indication]

Special Instructions or Potential Side Effects:
[Insert any specific instructions or warnings here]

Emergency Contact Information:
Physician Name: [Insert Name]
Phone Number: [Insert Phone Number]

I certify that the administration of this medication is necessary for the patient's health and ability to participate in daily activities following their discharge.

Sincerely,

[Physician Signature]
[Printed Physician Name]
[Medical License Number]
[Clinic/Hospital Name]