Date: [Insert Date]

To: [Facility Name / School Name / Healthcare Provider]
Attention: [Department or Contact Person]
Address: [Insert Address]

Subject: Patient Self-Administration Medication Authorization

Patient Name: [Insert Patient Name]

Date of Birth: [Insert Date of Birth]

I, [Physician Name], hereby authorize the above-named patient to self-administer the following medication(s) while under your supervision or care:

Medication Name	Dosage	Route (e.g., Oral, Inhaler)	Frequency / Time
[Medication 1]	[Dosage]	[Route]	[Frequency]
[Medication 2]	[Dosage]	[Route]	[Frequency]

Diagnosis/Reason for Medication: [Insert Diagnosis]

Authorization Details:

- I certify that this patient has been instructed on the proper administration of this medication.
- The patient has demonstrated the ability to self-administer the medication safely and effectively.
- The patient is authorized to carry the medication on their person (if applicable).

Special Instructions or Possible Side Effects: [Insert Instructions]

This authorization is valid from [Start Date] to [End Date/End of School Year].

Sincerely,

____
Physician Signature
Physician Name: [Insert Name]
Phone Number: [Insert Phone Number]
Medical License #: [Insert License Number]

Parent/Guardian Consent (if patient is a minor):

I give permission for my child to self-administer the medication listed above as directed by the physician.

____
Parent/Guardian Signature
Date: [Insert Date]