**Date:** [Insert Date]

**To:** [Name of School, Facility, or Caregiver]
**Address:** [Insert Address]

**Subject: Authorization for Administration of Prescription Medication**

To Whom It May Concern,

I, [Your Full Name], am the parent/legal guardian of [Child/Patient Full Name], born on [Date of Birth].

I hereby authorize the staff or designated personnel at [Name of Facility] to administer the following prescription medication to [Child/Patient Name] as prescribed by our physician.

**Medication Details:**

- **Medication Name:** [Name of Medicine]
- **Dosage:** [e.g., 5mg or 1 Tablet]
- **Route:** [e.g., Oral, Topical, etc.]
- **Time/Frequency:** [e.g., 12:00 PM or Every 4 hours]
- **Start Date:** [Date]
- **End Date:** [Date or "Until further notice"]
- **Reason for Medication:** [Optional: e.g., Allergy, Asthma]

**Special Instructions:**
[Insert any specific instructions, such as "Take with food" or storage requirements]

**Prescribing Physician Information:**
Name: [Doctor's Name]
Phone Number: [Doctor's Phone Number]

In case of any adverse reactions or emergencies, please contact me immediately at [Your Phone Number].

By signing this document, I release [Name of Facility] and its employees from any liability regarding the administration of this medication as instructed.

Sincerely,

_____
(Signature)
[Printed Name]
[Relationship to Patient]