WESTVIEW SCHOOL CORPORATION

Please circle school: **WJSH** **WES** **SES** **MES** **TES**

Medication Administration Authorization for Two Hour Delay Schedule

Student: _____ Date Of Birth:_____ Grade: _____

School Year: _____

For Lunchtime medications:

I, _____, parent of _____,

will call the School/School nurse if my student takes their am dose of _____ (medication name) at a later time than usual.

Otherwise the lunch dose of medication listed above will be given on a two hour delay schedule around _____.

For other scheduled Medications:

My child's medication is _____ and regularly takes his/ her medication at school around_____. On a two hour delay schedule my child should receive their medication (Initial as appropriate)

_____ At normal scheduled time

_____ Two hours later than usual

_____ Other:_____

I . _____, the parent, will notify the school nurse if there is a change in this plan or if my child takes his medication at a different time than usual.

Parent Signature: _____ Date: _____