Self-Administration of Non-prescription Pain Medication
Lakes International Language Academy- Upper School

Year_____________________ Grade____________________

Student Name____________________________________ Date of Birth____________________

Medication________________________________________

Purpose of Medication________________________________

I give permission for my student to self-administer the above medication at school for the purpose listed.

I understand the following guidelines must be followed:

• The medication must be a non-prescription pain medication (for example, Tylenol, Ibuprofen, Motrin). All other over-the-counter medications must follow Policy 344 LILA Medication Policy.

• The Medication may NOT contain ephedrine or pseudoephedrine as its sole active ingredient or as one of its active ingredients.

• The medication must be used as stated on the label (for example, one tablet every four hours as needed).

• The medication must be brought to school in a properly labeled bottle and not expired.

• The student must not share the medication with anyone else.

• The parent or guardian must submit written authorization for the student to self-administer the medication each school year.

If my student does not follow the above guidelines, I understand that his/her permission to self-administer the medication can be taken away.

_________________________________________________
Signature of parent/guardian          Date

_________________________________________________
Daytime phone number (work or other)        Cell phone number

District Fax #: Upper School- Headwaters Campus 651-464-8990