

## Medication at Lakeside School Instructions

- Please read and discuss Lakeside’s medication policy, including self-carry and self-administration expectations, with your student.
- **All medications** (prescription and over-the-counter) given at school require **written authorization from a parent/guardian and a licensed healthcare provider.**
- Whenever possible, schedule medication **outside school hours.**
- Medications provided in the Lakeside health room are oral pills. If your child requires a different formulation, like chewables or liquids, please provide it to the school nurse. If alternatives are not available, pills will be crushed for administration.
- Any medications not supplied by the school must be provided in the **original container** and labeled with the **student’s name, medication name/strength, dosage, timing, and duration.**

**Use this form to document medications not covered by specific Action Plans (e.g., Allergy, Asthma, Diabetes, Seizure). It includes short-term and as-needed medications, prescription meds (e.g., ADHD, migraines, depression), and over-the-counter meds used during school hours.**

If your child has an Action Plan that covers their prescribed medication, you do not also need to fill out this form for those same medications.

**An authorized medication form must be completed and on file at the student’s school, before medication can be stored or administered.**

UPPER SCHOOL STUDENTS	MIDDLE SCHOOL STUDENTS
<p><b>ATTN:</b> Joy Irvin, All-School Nurse  <b>PHONE:</b> (206)440-2906  <b>FAX:</b> (206)360-5092  <b>EMAIL:</b> <a href="mailto:nurse@lakesideschool.org">nurse@lakesideschool.org</a></p> <p><b>Lakeside School</b>  <b>ADDRESS:</b> 14050 1st Ave NE, Seattle, WA 98125</p>	<p><b>ATTN:</b> Alexis Mee, Middle School &amp; After-School Nurse  <b>PHONE:</b> (206)440-2924  <b>FAX:</b> (206)360-5092  <b>EMAIL:</b> <a href="mailto:nurse@lakesideschool.org">nurse@lakesideschool.org</a></p> <p><b>Lakeside Middle School</b>  <b>ADDRESS:</b> 13510 1st Ave NE, Seattle, WA 98125</p>

# Over-The-Counter Medication at Lakeside School

2026-2027 School Year

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Known Drug Allergies \_\_\_\_\_

Valid for 2026-2027 school year, covering June 8, 2026, through August 31st, 2027

And other dates as specified here \_\_\_\_\_

*The medications below reflect standard over-the-counter dosing ranges. Healthcare providers may adjust doses, add instructions, or cross out any medication as appropriate.*

Medication	Indication	Dose, Frequency, & Route (all per package instructions)	Additional Considerations (add as needed)
Motrin/ ibuprofen	Pain, headache, cramps, fever	PRN by mouth <b>10-11y/o:</b> 200 mg every 6-8 hrs (max 1,200 mg/day) <b>≥12y/o:</b> 200-400mg every 4-6 hrs (max 1,200mg/day)	Do not use for head injuries; can increase risk of bleeding
Tylenol/ acetaminophen	Pain, headache, cramps, fever	PRN by mouth <b>10-11y/o:</b> 325mg every 4-6 hrs (max 1,625mg/day) <b>≥12y/o:</b> 500-1,000mg every 6 hrs (max 3,000mg/day)	Do not use for head injuries; do not combine with other acetaminophen containing medications
Benadryl/ diphenhydramine	Seasonal allergies/ allergic reaction	PRN by mouth <b>10-11y/o:</b> 12.5-25mg every 4-6 hrs <b>≥12y/o:</b> 25-50mg every 4-6 hrs	Can cause drowsiness
Zytrec/cetirizine	Seasonal allergies/mild allergic reaction	PRN by mouth 5-10 mg once daily	
Hydrocortisone cream 1%	Skin irritation/ itching/rash	PRN topically Apply thin layer 1-2x daily	Do not use on broken skin or large surface area

Parent/Guardian Authorization:	Healthcare Provider Authorization:
<input type="checkbox"/> <b>YES- SELF-CARRY IN BAG / ON PERSON:</b> I request that my child be allowed to self-carry and self-administer medication <u>OR</u> I am 18 years or older and am signing this form on my own behalf  <input type="checkbox"/> <b>NO- ASSISTED ADMINISTRATION ONLY:</b> I request that the authorized persons assist my child in taking medication described above.	<input type="checkbox"/> <b>YES- SELF-CARRY &amp; SELF-ADMINISTER:</b> I have instructed this student in proper medication use. They may carry and self-administer. <b>An authorized adult will provide support if needed.</b>  <input type="checkbox"/> <b>NO- ASSISTED ADMINISTRATION ONLY:</b> Authorized persons should administer the medication as prescribed. Medication should be stored safely and accessibly, but not carried by student.

Additionally, I/We authorize communication between the school nurse and my/our child's healthcare provider below as necessary to support the safe management of medication at school.

Parent/Guardian Signature (or Self if 18+):	Licensed Healthcare Provider Signature:
Printed Name: _____ Date: _____	Printed Name: _____ Date: _____

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Valid for  2026-2027 school year, covering June 8, 2026, through August 31st, 2027

Other dates: \_\_\_\_\_

**Medication Information (Complete ONE medication per page):**

Medication Name:

Strength/Dosage:

Route (ex. by mouth, topical, inhaled):

Frequency/Time of Day:

Indication/Reason for Medication:

Probable Side Effects:

Special Instructions/Other Notes:

**Parent/Guardian Authorization:**

**YES– SELF-CARRY IN BAG / ON PERSON:** I request that my child be allowed to self-carry and self-administer medication OR I am 18 years or older and am signing this form on my own behalf.

**NO– SCHOOL STORAGE & ASSISTED ADMINISTRATION ONLY:** I request that the medication be stored in the health room and authorized persons at my school assist my child in taking medication described above.

**Healthcare Provider Authorization:**

**YES– SELF-CARRY & SELF-ADMINISTER:** I have instructed this student in proper medication use. They may carry and self-administer. **An authorized adult will provide support if needed.**

**NO– SCHOOL STORAGE & ASSISTED ADMINISTRATION ONLY:** Authorized persons should administer the medication as prescribed. Medication should be stored safely and accessibly, but not carried by student.

Additionally, I/We authorize communication between the school nurse and my/our child’s healthcare provider below as necessary to support the safe management of medication at school.

**Parent/Guardian Signature (or Self if 18+):**

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Licensed Healthcare Provider Signature:**

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_