



Crosslake Community School  
35808 County Road 66  
P.O. Box 1020  
Crosslake, Minnesota 56442  
218-692-5437

**516FRM - Student Self-Administration Form**

**Non-Prescription Pain Relievers/ Cough Drops**

5<sup>th</sup>- 8<sup>th</sup> grade students may self-carry and administer non-prescription pain medication/ cough drops during the school day provided that:

1. This form must be completed and into the health office. This form is to be completed each school year.
2. The medication is brought in the original container/ bag with the student's name written on the label.

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time or frequency): \_\_\_\_\_

Reason for use: \_\_\_\_\_

Allergies: \_\_\_\_\_

Cough drops: Yes: \_\_\_\_ No: \_\_\_\_

TO BE COMPLETED BY THE PARENT/GUARDIAN I hereby give permission for my child to self-carry and self-administer non-prescription pain medication and or cough drops. I understand that my child is to carry this medication with him/her at all times or keep it locked in his/her locker at school and that my child is not to share this medication with other students. The non-prescription pain medication and cough drops must be in the original container and used according to the label. I understand that the school may revoke the student's privilege to possess and use non-prescription pain relievers if it is determined that the student shared with other students or did not take as authorized by their parent/guardian and by the directions on the label.

Signature of Parent/Guardian: \_\_\_\_\_

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

TO BE COMPLETED BY THE STUDENT I agree to use non-prescription pain medications and cough drops correctly and keep them in their original container. I will not share my medication with anyone else.

Signature of Student: \_\_\_\_\_

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

TO BE COMPLETED BY THE Health Office Signature of Health Office Personal:

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