Oakland School District
Medication Form
2024-2025 School Year

DOCTOR FILLS IN REQUIRED SECTIONS. Parents sign and return completed form to the school nurse. This form is required for over-the-counter or prescription medication administered in school. Please do not make any changes to this form

STUDENT: _____ GRADE: _____

DATE OF BIRTH: _____ HOME PHONE: _____

Medication taken at home YES: _____ NO: _____

Name of Medication(s) taken at home: _____

_____

The following **prescription medication** may be administered to my patient:

MEDICATION: _____ DOSAGE: _____

TIME TO BE GIVEN: _____ GIVEN FOR: _____

SIGNIFICANT SIDE EFFECTS: _____

The following **over-the-counter medication(s)** may be administered to my patient:

Cough Drop: _____ How frequently: _____ As needed for: _____

Tylenol: 325 mg _____ How many:_____ How Frequently: _____
OR 160 mg _____ How many:_____ How Frequently: _____
As needed for:_____

Motrin/Advil: 200 mg _____ How many: _____ How frequently: _____
OR 100 mg _____ How many: _____ How frequently: _____
As needed for:_____

Benadryl: Dosage: _____ How frequently:_____ As needed for: _____

Doctor Name (print): _____ Date: _____

Doctor Signature: _____ **Doctor Stamp**:

I request for my child, _____, to receive medication as listed above. I have been informed that the school district, its agents, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medication to my child. I hereby indemnify and hold harmless the Oakland Board of Education, its agents, and employees from any and all claims.

Parent Name (print): _____ Date _____

Parent Signature: _____

Return this form only if you want to authorize medication administration