

**Oakland School District  
Medication Form  
2025-2026 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 or OTC 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:** \_\_\_\_\_

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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*