Tri-County Area School District
409 S. West Street
Plainfield, WI. 54966

Phone 715-335-6366
HS ext. 4910 Fax: 715-335-6322
ES ext. 2910 Fax: 715-335-6364

Over-the-Counter Medication Consent Form

Student's Name: ____________________DOB: __________Grade:______

Parent/Guardian to complete form and provide medication.

Over-the-Counter Medication: _________________________

Reason to Administer: _____ Headache ______Common Cold Symptoms ______Sore throat

______Mild Muscular Skeletal Pain _______ Other

Dose: ____________________ Frequency/Times _____________________

Start Date: _____________________ Stop Date: ______________________

Possible Side Effects: ____

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I give my permission to school nurse/designated school personnel to administer to my child over-the-counter medication listed above according to directions provided on this form. I agree to hold the Tri-County School District and school nurse/designated school personnel harmless in any claims arising from the administration of this medication. I agree to notify the school in writing of any changes in the above order.

____ ____________________

Parent/Guardian Signature Date

Board approved: 2/24/2016