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: _____

_____

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