Mercer County Special Services School District

Joseph Cappello School Fax#- (609) 588-8474
Mercer Elementary School Fax#- (609) 570-1132
Mercer High School Fax#- (609) 631-2136

SELF-ADMINISTRATION MEDICATION PERMISSION FORM

SCHOOL YEAR 20___ - 20____

I hereby request permission for my child, ______________________________, ________________
(Name) (DOB)
a student at Mercer County Special Services School District(MCSSSD), to be given prescription medication at school during school hours, and in so doing, release the school nurses and physicians and the Mercer County Special Services School District of responsibility for any untoward reaction my child may incur as a result of taking said medication. I have obtained the following instructions from my child's doctor (to be completed and signed by doctor):

Diagnosis____

Name of Medication	Dosage	Time taken during school

Possible side effects of the medication: ____

Beginning date is: July 1, 20____ **Last date June 30, 20____**

____
Doctor's Signature

____
Date

____
Doctor's printed name or stamp

____
Approved by School Medical Inspector

____
Date

Medication must be brought to school in the ORIGINAL CONTAINER by a parent/guardian or responsible adult.

_________________________Date _________________________Parent Signature