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
SCHOOL YEAR 20___ -20___

I request permission for my child, _____,
(Child's Name) (DOB)
a student at Mercer County Special Services School District, to be given 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(s) 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 health care provider):

1. Diagnosis

_____

2. Name of Medication(s) Dosage Time taken during school

_____

_____

3. If this is a stimulant medication for Attention Deficit Disorder or a tricyclic antidepressant, has this child been evaluated for cardiac risk according to AAP guidelines? (Stimulant ADD medications and tricyclic antidepressants will not be given in school without a cardiac risk evaluation).

_____ ***Yes, this child has been evaluated for cardiac risk. (Please initial)***

4. Possible side effects of the medication(s): _____

_____

5. When the morning dose (at home) is omitted, the medication may be given at school upon parental request:

Yes _____ No _____

6. On days when field trips are taken, medication may be given to child upon return to school

Yes _____ No _____

7. Beginning date is July 1, 20____ Last date June 30, 20____

_____ _____ _____
Health Care Provider's signature *Health Care Provider's printed name or stamp* *date*

_____
School Medical Inspector Approval

_____ _____
Parent signature REQUIRED ***Date***

MEDICATION MUST BE BROUGHT TO SCHOOL IN ORIGINAL LABELED BOTTLE BY PARENT OR GUARDIAN.