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

PROCEDURE PERMISSION FORM
SCHOOL YEAR 20__- 20__

I hereby request permission for my child _____
(Name) (DOB)
A student at Mercer County Special Services School District, to have prescribed procedures done 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 the said procedure. I have obtained the instructions from my child's doctor:for example: If a mic-G-Tube falls out during the school day, the school nurse will be able to replace the tube with a doctor's order.

INSTRUCTIONS TO BE FILLED IN AND SIGNED BY THE DOCTOR

Diagnosis_____

Name and Description of Procedure_____

_____

_____

Beginning date is: **July, 20___** **Ending date is : June 30, 20___**

Date_____ **Doctor's Signature** _____

Doctor's printed name or stamp

_____ _____
Approved by School Medical Director **Date**

_____ _____
Signature of Parent/Guardian **Date**