Mercer County Special Services School District

Joseph Cappello School- (609) 588-8485 Fax# 16093318363(*must dial all #s)
Mercer Elementary School-(609) 570-1120 Fax# 16093318533 (*must dial all #s)
Mercer High School- (609) 588-8450 Fax# 16093318491 (*must dial all #s)

PROCEDURE PERMISSION FORM
SCHOOL YEAR 20___ -20___

I request permission for my child _____,
(**Child's Name**) (**DOB**)

a student at Mercer County Special Services School District, to have prescribed procedures done during the 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 G-tube falls out during the school day, the school nurse may replace the tube with a doctor's order and supplies provided by parent/guardian.

INSTRUCTIONS TO BE COMPLETED AND SIGNED BY THE DOCTOR AND PARENT

Diagnosis: _____

Name and Instructions for Procedure*:*

_____

_____

_____

Beginning date is September 1, 20____ **Last date is August 31, 20____**

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

_____ _____
Signature of Parent/Guardian **DATE**