

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: September 1, 20__

Last date August 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