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)

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***

_____

_____

_____

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

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

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

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