The School District of Haverford Township

Physician's Order - Self Administration

Physician's Order	Parent/Guardian Request
Please allow for the following emergency medication to be carried and self-administered on school property. This student has demonstrated the capability to safely administer their own medication. Name of Patient: Name of Medication: Prescribed Dosage: When Administered: Directions for Administering: Possible Side Effects and Treatment: Date Prescribed: _____ Signature of Physician _____ Name of Physician Address of Physician: Physician's Phone Number:	I request that my child _____ be allowed to carry and self-administer their own emergency medication as prescribed. I acknowledge that the school is not responsible for ensuring the medication is taken and relieve the District and its employees of responsibility for the benefits or consequences of the prescribed medication. I have read and understand School Board Policy 210 and the administrative regulations that accompany the policy. _____ Signature of Parent/Guardian Date

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