1110 Fairfield Avenue, Suite 100
P.O. Box 25940
Eugene, OR 97402
Web Address:
www.eugenecreativecare.org
Email: creativecare.eugene@gmail.com

HEALTH CONDITION RELEASE AGREEMENT

This is to serve as a Release Agreement between Eugene Creative Care and myself for any Eugene Creative Care representative to follow the detailed procedure provided by you or your child's primary care physician for the disclosed medical condition below. I further understand that if the situation results in ambulance transport or medical attention, it is my responsibility to cover those charges.

TODAY'S DATE:	PROGRAM ATTENDING:		ECC HEAD TEACHER:
PARENT/GUARDIAN NAME:			
CHILD'S NAME:			
PRESCRIBING PHYSICIAN:			
MEDICAL CONDITION:			
WAS A COPY OF THE PHYSICIAN'S INSTRUCTIONS OR DIAGNOSIS SUPPLIED TO EUGENE CREATIVE CARE?	PLEASE CIRCLE ONE:	YES	NO
PLEASE PROVIDE DETAILED PROCEEDURES FOR HANDLING MEDICAL CONDITION ABOVE:			
PLEASE PROVIDE DETAILED PROCEEDURES FOR FOLLOW UP IF ANY:			
DO YOU WANT ECC TO CONTACT THE PHYSICIAN ON RECORD?	PLEASE CIRCLE ONE:	YES	NO

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT AND AGREE TO THE TERMS OF THE RELEASE

PARENT/GUARDIAN SIGNATURE: ______________________________

ECC ADMINISTRATIVE REPRESENTATIVE SIGNATURE: ______________________________

MEDICATION AUTHORIZATION FORM

This is to serve as a Release Agreement between Eugene Creative Care and myself for any Eugene Creative Care representative to administer prescribed, by licensed medical professional, any medication, which I ave supplied for my child (listed below). I understand that upon administering medications, it is the policy of Eugene Creative Care to contact the parent/guardian unless otherwise requested. I further understand that if the situation results in ambulance transport or medical attention, it is my responsibility to cover those charges.

ALL PRESCRIBED MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER LABELED WITH THE CHILD'S NAME, EXPIRATION DATE, THE PRESCRIBING PHYSICIAN, DOSAGE AND FREQUENCY OF ADMINISTRATION.

TODAY'S DATE:	ECC PROGRAM ATTENDING:		ECC HEAD TEACHER:
PARENT/GUARDIANS NAME(s):			
	LAST NAME, FIRST NAME		PHONE NUMBER
CHILD'S NAME:			
NAME OF PRESCRIBED MEDICATION:		DOSAGE:	FREQUENCY:
NAME OF PRESCRIBING PHYSICIAN:			
WAS A COPY OF THE PHYSICIAN'S	PLEASE CIRCLE ONE: YES NO		
THIS MEDICATION SHOULD BE CONTINUED FOR:	# OF DAYS:	START DATE:	
	(IF APPLICABLE)	END DATE:	
REQUEST THAT ECC STAFF CONTACT UPON ADMINISTRATION: (PLEASE CIRCLE ALL THAT APPLY)	PARENT/GUARDIAN:	YES OR NO	PHONE #(S) TO CONTACT
	PHYSICIAN ON RECORD:	YES OR NO	PHONE #(S) TO CONTACT
	EMS:	YES OR NO	PHONE #(S) TO CONTACT

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT AND AGREE TO THE TERMS OF THE RELEASE

____________________ PARENT/GUARDIAN PRINTED NAME

____________________ PARENT/GUARDIAN SIGNATURE

A COPY OF THE MEDICATION RECORD FOR YOUR CHILD CAN BE REQUESTED AT ANY TIME