AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

I hereby authorize and release the Athena-Weston School District and it's employees from any and all claims resulting from administering medication to my child(ren).

Child's Name____

Name of Medication____

Frequency and Dosage ____

Physicians Name______________________________ Phone__________

Name of Medication ____________________________

Frequency and Dosage __________________________

Physicians Name______________________________ Phone__________

To be in compliance with ORS 339.870 no school employee will administer any medication, prescription or non-prescription, without the guardian's written consent and written instructions from a physician. All medications must be administered from the office and in the original container naming the medication, dosage and frequency.

Non-prescription Medication______________________________

Frequency and Dosage_________________________________

Legal Guardian Signature______________________________

Please note any medical information we might need to know concerning your child at school.

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No medication will be given to your child without this record on file in the school office. See Medication Procedures in your handbook.

___________________________________ Date_______________

Parent/Guardian Signature