REFUSAL TO PROVIDE MEDICATION

PROGRAM SITE: _____

FROM: _____
(parent/guardian name)

REGARDING: _____ DATE OF BIRTH: _____
(child's name)

When I enrolled my child at your school/site, I informed you that my child has the following medical condition(s)_____.
However, at this time I do not wish to supply you with any medication for the above-mentioned condition(s) and I take full responsibility for any reactions or problems related to my child's condition while he/she is in your care. I acknowledge that I have been informed that if any emergency situation occurs, 911 will be called to provide care for my child. I also understand that if 911 is called, I am financially responsible for any bills incurred.

I have reviewed this with my child's medical care provider and their signature is below to concur with my decision in regards to my child's medical condition.

Parent/Guardian Signature:	Date:
Parent/Guardian Printed Name:	
Signature of Health Care Provider:	License Number:
Health Care Provider Printed Name:	
Phone Number:	Date:

Any changes to this form must be signed with time and date noted.

If a parent chooses to cross off an allergy, he/she must also write a note stating such.

☐ Parent/Guardian Copy ☐ BASE Copy ☐ School/Nurse Consultant Copy ☐ Student File Copy