



**Our Lady of Hope Catholic School
REFUSAL TO PROVIDE MEDICATION & WAIVER OF LIABILITY
FORM**

Child's Complete Name

Date of Birth

Child's Health Condition

I _____, parent of _____, do not wish to supply _____ (School) with any medication for the above mentioned health condition. I take full responsibility for any reactions or health problems related to my child's health condition while he or she is under the care of _____ (School) or any of its staff members. I give consent, that in the event of an emergency any members of the school may contact 911 in order for emergency care to be provided to my child.

In light of my voluntary refusal to supply this medication, I further agree to indemnify _____ (School), any of its staff members, its volunteers, and the Diocese of Arlington for any and all expenses incurred from actions due to complications my child experiences because of the above-named health condition, including the costs for emergency transport to a health care facility.

I freely execute this Acknowledgement with full knowledge of its content.

Parent or Guardian Signature

Date

Signature of School Official

Date