MEDICAL AUTHORIZATION FORM
FOR
FIRST BAPTIST CHRISTIAN DAY SCHOOL
7300 GARY STREET
SPRINGFIELD, VIRGINIA 22150
703-451-7144

_____
(date)

I, _____, the parent of _____,
(print parent's name) **(print child's name)**
give the staff of First Baptist Christian Day School my permission to seek medical attention for my child in the event that I cannot be reached.

_____ _____
(parent's signature) **(signature of notary)**

List any medical conditions or allergies that a doctor should be aware of before treating your child:

_____
_____

_____
(notary's seal)

_____
(Commission expiration date)

List any medications your child takes <u>REGULARLY:</u>

_____
_____

* * * * * * * * * * * * * * * * * * * *

For office use only:

Child's Name: _____

Class: _____