MEDICAL AUTHORIZATION FORM

FOR

FIRST BAPTIST CHRISTIAN DAY SCHOOL

7300 GARY STREET

SPRINGFIELD, VIRGINIA 22150

703-451-7144

katie@fbcspringfield.org

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (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 witness)