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)