

**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 REGULARLY:**

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

\* \* \* \* \*

**For office use only:**

**Child's Name:** \_\_\_\_\_

**Class:** \_\_\_\_\_