

First Baptist Child Development Center

Six Month Authorization of
EMERGENCY MEDICATIONS
[Benadryl, Epipen, etc]

Child's Name: _____ Date: _____

I authorize First Baptist Child Development Center to administer the following medication to my child whose name is noted above on an as needed basis following specific instructions.

Name of medication/special medical procedure:

Physician's Name	Business Address	Office Number	Emergency Number
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Pharmacist's Name	Business Address	Office Number	Emergency Number
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Reason/Desired Effect(s):

Plan of Action for Emergency Medications

(Must include **how** and **when** to administer)

Storage Instructions:
