

First Baptist Child Development Center  
Authorization of

**OVER THE COUNTER MEDICATIONS**

[ex: Benadryl, Robitussin, Triaminic, etc.]

**\*\*All medicines must be taken home each night and signed for administration each day\*\***

**Each medication must be in its original container labelled with child's name along with dosage recommended by physician.**

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 treatment: \_\_\_\_\_ Dosage and time to be given \_\_\_\_\_ a.m./p.m.

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason/Desired effect(s): \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Storage Instructions: \_\_\_\_\_

Side Effects: \_\_\_\_\_

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Parent's Signature

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Date of Authorization

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