First Baptist Child Development Center
Authorization of

# PRESCRIPTION MEDICATIONS

[temporary prescription medications such as cough medicine]
**All medicines must be taken home each night and signed for administration each day**

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

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Parent's Signature Date of Authorization

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