

ANTIOCH FELLOWSHIP MISSIONARY BAPTIST CHURCH MEDICATION AUTHORIZATION FORM

I hereby request an employee to administer the medication named below to my child. I understand that all medications must be in the original container, labeled with the child's name and with directions to administer the medication. Prescribed medication must also include the date and name of physician. By signing below, I release the Antioch Fellowship Missionary Baptist Church, its directors, officers and employees from all liability for any and all reactions from which my child may suffer from this medication.

| | 0 | | _ | Time to | | Dosage Given | Date & Time | Employee's Full Name |
|------|--------------|--------------------|--------|----------|--------------------|-----------------|-------------|-------------------------|
| Date | Child's Name | Name of Medication | Dosage | Be Given | Parent's Signature | Given | Given | Full Name |
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