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.

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