2025 Parent Permission for Medication Administration

Child's Name: ____ Date of Birth: _______________

I hereby grant permission for designated agents of Nashville First Baptist Church to give my child the following prescription medications which I have supplied:

Name of Medication: ________________________________ For (Reason): ________________________

Dosage (How Much): ________________________________ How Often: _________________________

Specific instructions or side effects for which to watch: ____

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Dosage (How Much): ________________________________ How Often: _________________________

Specific instructions or side effects for which to watch: ____

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Name of Medication: ________________________________ For (Reason): ________________________

Dosage (How Much): ________________________________ How Often: _________________________

Specific instructions or side effects for which to watch: ____

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Allergy Alert! My child is allergic to the following: ____
(medicine, food, insect bites, plants, etc.)

OVER THE COUNTER MEDICATION (please circle yes or no for each medication listed!)
In addition, designated agents of First Baptist Nashville may administer the following over the counter medications on an "as needed basis" as deemed necessary or beneficial:

Tylenol (acetaminophen): Y N
Cough/cold medications: Y N
Antacids: Y N
Imodium: Y N

Motrin/Advil (ibuprofen): Y N
Benadryl (diphenhydramine): Y N
Neosporin or hydrocortisone creams/ointments: Y N
Dramamine (meclizine, for motion sickness): Y N

I prefer to receive a call prior to **ANY** over the counter medications being administered: Y N

If **YES**, please supply the best number to call day or night: ______________________________________

Signature of parent or legal guardian: ____Date: ___________