

# Medical Authorization Form

Child's Full Name \_\_\_\_\_

Parent's Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Instructions:

I authorize a Risen Kids adult volunteer to administer medication in case of emergency as described above.

Parents Signature \_\_\_\_\_ Date \_\_\_\_\_