MEDICATION AUTHORIZATION FORM

Riverbend Retreat Center, July 2-5, 2026

Student Name: _____ DOB: _____ Completed Grade: _____

Physician: _____ Physician's ph#: _____

Emergency contact: _____ Phone: _____

ALLERGIES:_____

PRESCRIPTION MEDICATION	DOSAGE	FREQUENCY

☐ Checking this box acknowledges that my student may receive any and all OTC medications as needed for their medical benefit.

By signing this document, I acknowledge that I am the parent/guardian of the student listed above, and I further acknowledge that Fielder Church is not a medical provider but only assisting my child with their prescribed and/or OTC medication(s) as scheduled/needed.

(Students 18 and older at the time of Camp must sign their own consent.)

Parent/Guardian Name: _____ Phone#: _____

Parent/Guardian Signature: _____ Date: _____