PIONEER MINISTRIES, Inc.
P.O. Box 6182 • Jackson, MS 39288-6182 • Ph 601-939-1950 • Email: pminis3659@aol.com • www.pioneerministries.org

Camp Pioneer Medication Consent For Minors

Campers who are on prescribed medications will take their medications with nursing staff supervision. All medications must be in properly labeled containers that identify the medication, dose, how to take medication, and expiration date. Please list below the medications you are giving your child consent to take:

Allergies: _____

Name of Medication	Dose	Schedule Times	Expiration
_____	_____	_____	___ / ____
_____	_____	_____	___ / ____
_____	_____	_____	___ / ____
_____	_____	_____	___ / ____
_____	_____	_____	___ / ____
_____	_____	_____	___ / ____

Additionally, I consent to the following as needed medications:

Tylenol by package instructions for age as needed for Headache or Pain Yes __ No __
Ibuprofen by package instructions for age as needed for Headache or Pain Yes __ No __
Pepto Bismol by package instructions for age as needed for upset stomach Yes __ No __
Benadryl by package instructions for seasonal allergies or allergic reactions Yes __ No __

I, _____, give consent for camper _____
(print name) (print name)
to take the medications listed above.

Signature of Parent or Guardian _____/ Date: _____
Signature of Staff Member _____/ Date: _____