



California Fall Retreat Application Form 2014

Since 1963

“an Experiment in Christian Living”

Retreat Name: General Fall Retreat
Retreat Dates: October 10-13.2014
Retreat Directors: Jim and D’Ann Lesch

Camper Information Please complete a separate form for each person attending camp.

Name of Camper _____
Address _____ Phone _____
City _____ State _____ Zip _____ Camper Email _____
Birth (MM/DD/YYYY) _____ Age (by start of camp) _____ Male Female Grade Completed _____

Emergency Contact Information Campers MUST have two emergency contacts to attend camp

Contact #1

Name _____ Relationship _____
Address _____
City _____ State _____ Zip _____ Email _____
Home Phone _____ Work Phone _____ Cell Phone _____

Contact #2

Name _____ Relationship _____
Address _____
City _____ State _____ Zip _____ Email _____
Home Phone _____ Work Phone _____ Cell Phone _____

Deadlines & Fees Applications should be received one month prior to camp/retreat start date. Camp Blessing reserves the right to cancel a camp/retreat if registration is inadequate. **Retreat cost is \$25 for all participants over 18 years;** please include payment with your application.

Please return California Applications and Forms to:

David Karavas
20914 Rancherias Road, Apple Valley, CA 92307
(760) 247-8252

Photo Release By attending a Camp Blessing event, you grant permission to use photos of the attendee in Camp publications such as, but not limited to, brochures, web sites, and camp reports.



Medical Information & Health History Form 2014

Please include accurate health information that the Camp Director, Staff, and Nurse should be aware of to insure well-being of campers.

All forms are available at www.campblessing.com

Medical record for (name) _____ **Date:** _____

Health History

 Please check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Disease/defect | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Other |

Details _____

Diet: _____

Allergies

 Please indicate all that apply

- | | |
|--|-----------------------------|
| <input type="checkbox"/> Food | Symptoms to watch for _____ |
| <input type="checkbox"/> Drug | _____ |
| <input type="checkbox"/> Animals | Action to take _____ |
| <input type="checkbox"/> Insect Bites | _____ |
| <input type="checkbox"/> Plant/pollens | |
| <input type="checkbox"/> Other: _____ | |

Exceptions and Limitations

 Please list special considerations for this camper. (i.e. sleep disorder, bedwetting, physical, emotional, or behavioral concerns)

Considerations _____

Actions to take _____

Permissions

 Please initial the line to the left of each statement, then sign and date the bottom. All campers must have authorization to stay and participate at Camp Blessing.

____ I grant permission for any emergency treatments (including medical, surgical, anesthesia of other procedure) deemed necessary for the camper listed above during his/her stay at Camp Blessing. It is understood that emergency treatment will be performed at a local hospital.

Health Insurance Provider _____
ID# _____ Group# _____ Phone/approval # _____

____ I grant permission for the nurse to administer medications prescribed by a physician, to treat minor injuries and to administer over the counter medications such as Tylenol, Benadryl, cough drops, antacids, antibiotic ointment, topical pain reliever.

____ The camper listed above has permission to participate in all camp activities, including field trips off camp grounds. Please list exceptions on back.

Parent/Guardian _____ **DATE** _____



Medication Record Health Form 2014

**This page MUST be filled out completely if the applicant is taking medications of any type.
All medications MUST be in their original containers and clearly labeled with applicants name
and current instructions.**

Medication record for (name) _____ **Date:** _____

Medication Instructions

Bring all medications to Camp Nurse upon arrival. All medications will be kept secured in the Nurse's Office. The Camp Health Supervisor cannot dispense medications unless:

1. Medication is in original container.
2. Camper's name is clearly labeled on container.
3. Instructions listed below must match label on container.
4. Medication form must be signed by child's MD/NP/PA

Medication name: _____

Dose and route: _____

Time to be given: _____

Specific Instructions or Reason to contact Physician: _____

Medication name: _____

Dose and route: _____

Time to be given: _____

Specific Instructions or Reason to contact Physician: _____

Medication name: _____

Dose and route: _____

Time to be given: _____

Specific Instructions or Reason to contact Physician: _____

Medication name: _____

Dose and route: _____

Time to be given: _____

Specific Instructions or Reason to contact Physician: _____

Physician/Practitioner's signature directs the above medication administration and indicates his/her willingness to communicate with person who administers the medication.

Name of Physician/Practitioner _____

Address _____ Phone _____

City _____ State _____ Zip _____

Physician/Practitioner Signature _____ Date _____

Parent/Guardian _____ **DATE** _____