

California Teen/College Retreat **Application Form 2014**

Since 1963

"an Experiment in Christian Living"

Retreat Name: Teen/College Retreat January 17-20 **Retreat Dates: Retreat Directors:** Wayne and Kathy Urbaniak **Camper Information** Please complete a separate form for each person attending camp. Name of Camper ____ Address Phone City Camper Email Emergency Contact Information Campers MUST have two emergency contacts to attend camp Contact #1 Name _____ Relationship _____ City_____ State___ Zip ____ Email ____ Contact #2 Name _____ Relationship _____ 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:

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.

20914 Rancherias Road, Apple Valley, CA 92307

(760) 247-8252

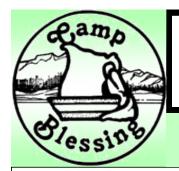


Medical Information & Health History Form 2014

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: |
|--|---|--|
| Hypertension Epilepsy Bleeding Disorders | Ear InfectionsHeart Disease/defectMusculoskeletal DisordersHay fever | Diabetes Asthma Skin Conditions Other |
| Details | iet: | |
| Allergies Please indicate all that apply Food Drug Animals Insect Bites | Symptoms to watch for Action to take | |
| Plant/pollens Other: Exceptions and Limitations Ple | | i.e. sleep disorder, bedwetting, physical, |
| emotional, or behavioral concerns) Considerations | | |
| Actions to take | | |
| Permissions Please initial the line to the leto stay and participate at Camp Blessing. | eft of each statement, then sign and date the bott | tom. All campers must have authorization |
| camper listed above during his/her stay at Camp I Health Insurance Provider | | ent will be performed at a local hospital. |
| ID#Group# | | |
| I grant permission for the nurse to administer counter medications such as Tylenol, Benadryl, co | medications prescribed by a physician, to treat a ough drops, antacids, antibiotic ointment, topica | |
| The camper listed above has permission to pations on back. | articipate in all camp activities, including field tr | ips off camp grounds. Please list excep- |
| 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 cannot dispense medications unless: | will be kept secured in the Nurse's Office. The Camp Health Supervisor |
| 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: | |
| Medication name: Dose and route: | |
| 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: | |
| Medication name: Dose and route: | |
| Time to be given: | |
| Specific Instructions or Reason to contact Physician: | |
| Physician/Practitioner's signature directs the communicate with person who administers the medication. Name of Physician/Practitioner | e above medication administration and indicates his/her willingness to |
| | ni . |
| Address | Phone |
| CityStateZip | |
| Physician/Practitioner Signature | Date |
| Parent/Guardian | DATE |