Camp Blessing
Camper Application Form 2014

Since 1963
"an Experiment in Christian Living."

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 _____

2014 Camp Schedule:
Please complete a form for all camps this camper will be attending.

☐ Special Persons Overnight June 21-25 ☐ Special Person's Day July 21-25

Deadlines:
Applications should be received **one month** prior to camp start date. Camp Blessing reserves the right to cancel a camp/retreat if registration is inadequate.

Where to return Applications:
WI: Sara Lenzner, 822 N. 3rd Ave, Wausau, WI 54401; (715) 842-8499

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 _____

Photo Release
By signing below you grant Camp Blessing permission to use photos of this camper in Camp publications, such as brochures, web site, & camp reports.

Parent/Guardian_____ Date _____

Camp Blessing
Special Person's Camp
"Getting to Know the Camper"

Camper name: _____

Activities the camper enjoys: _____

_____

_____

Activities the camper does not enjoy: _____

_____

_____

Can the camper read? ☐ Yes ☐ No Can the camper write? ☐ Yes ☐ No

Is the camper verbal? ☐ Yes ☐ No Is the camper ambulatory? ☐ Yes ☐ No

(If not verbal how does camper communicate?) _____

_____

_____

What is challenging for the camper to do?

_____

_____

_____

Has the camper ever been away from home? ☐ Yes ☐ No

Has the camper ever been to Camp Blessing? ☐ Yes ☐ No

What else would help us get to know the camper better? _____

_____

_____

FORM A

MEDICAL INFORMATION &HEALTH HISTORY– CAMP BLESSING

Please include accurate health information that the Camp Director, Staff, and Nurse should be aware of to insure well-being of campers. A current physical exam form must be resubmitted every 2 years. All forms are available at www.campblessing.com.

Medical record for (name) _____ Date: _____

Health History Please check all that apply

__ Seizures
__ Hypertension
__ Epilepsy
__ Bleeding Disorders
__Ear Infections
__ Heart Disease/defect
__ Musculoskeletal Disorders
__ Hay fever
__ Diabetes **Diet**_____
__ Asthma
__ Skin Conditions
__ Other

Details_____
_____

ALLERGIES Please indicate all that apply

__ Food
__Drug
__Animals
__Insect Bites
__ Plant/pollens
__ Other: _____

Symptoms to watch for_____
_____

Action to take_____
_____

Exceptions and Limitations Please list special considerations for this camper. i.e. may include sleep disorder, bedwetting, or any physical, emotional, or behavioral concerns:_____

_____
_____

__ Takes medications: complete form B. Medications must be in their original containers and clearly labeled with camper/staff name and current instructions.

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 - CAMP BLESSING

FORM B

Bring all medications to Camp Nurse upon arrival. All medications will be kept in the Nurse's Office.

To be signed by your MD/PA/NP

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

Camper's Name_____ Date_____

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: _____
_____

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.

Physician/Practitioner's name, address, phone

_____ _____
_____ Signature (prescription meds only)
_____
_____ _____
Date signed

I hereby give permission to the Camp Health Supervisor to give the above medication to my child according to the instructions stated above and further authorize them to contact my child's physician if necessary.

PARENT SIGNATURE_____ date_____

PHYSICAL EXAM FORM – CAMP BLESSING

FORM C

To be completed and signed by your MD/PA/NP
Campers must have PHYSICAL EXAM (form C) performed within the past 24 months. It is to be on file at Camp Blessing.

Name of Camper/Staff:_____
Date of Birth_____ **Date of Exam**_____

IMMUNIZATIONS: This person has been immunized in accordance with the recommended immunization schedule appropriate for his/her age as approved by the CDC and the American Academy of Pediatrics.
___Yes
___ No
___ Immunizations have been declined by parents for religious or medical reasons.
Date of last Tetanus_____

Parent/Guardian Signature_____ Date_____
Please attach a copy of complete immunization record to this form.

Examination:

Essential findings_____
Health problems that camp should be aware of_____
_____
Please explain what to watch for_____
_____
Identify any health risks (i.e. allergies, etc. _____
Action to take_____

Recommendations for restriction of physical activity at camp.
____ None
____ Yes-Explain_____
_____

Medications: If this camper is currently taking medication to be given while attending camp, please list them on and sign **FORM B.**
* Note for Special Person's Camp: If additional space is needed for medication – please list additional medications on back of form "B".

In my opinion, this person's condition allows participation in an active camp program.
Signature of MD/PA/NP_____ Date_____
Print Name and Address and Phone Number of above_____
_____
_____

Send completed forms to: Sara Lenzner, 822 N. 3rd Ave. Wausau, WI 54401 (715-842-8499).