



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.

Children' Camp July 13-18 Teen Camp July 27-Aug 2

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

Camper 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 _____

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

- | | | | |
|---|--|--|-------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Diabetes | Diet _____ |
| <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 _____

ALLERGIES Please indicate all that apply

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

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).