

Wisconsin Adventure Retreat Application Form 2014

Since 1963 "an Experiment in Christian Living"

Retreat Name: Adventure Retreat **Retreat Dates: August 15-17 Retreat Directors:** Mike Fischer **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 ____ Home Phone _____ Cell Phone _____ Contact #2 Name _____ Relationship _____ Home Phone _____ Cell Phone _____ **Deadlines & Fees** Applications should be received one month prior to camp/retreat start date. Camp Bless-

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 Wisconsin Applications and Forms to:

Sara Lenzner 822 N. 3rd Ave, Wausau, WI 54401 (715) 842-8499

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.

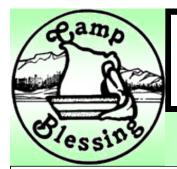


Medical Information & Health History Form 2013

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 app		201
Seizures	Ear Infections	Diabetes
Hypertension Epilepsy	Heart Disease/defect Musculoskeletal Disorders	Asthma Skin Conditions
Epilepsy Bleeding Disorders	Hay fever	Other
Bleeding Bisorders		<u> </u>
Details		
Diet:		
Allergies Please indicate all that apply		
Food	Symptoms to watch for	
Drug		
Animals		
Insect Bites	Action to take	
Plant/pollens		· · · · · · · · · · · · · · · · · · ·
Other:		
Exceptions and Limitations Placemotional, or behavioral concerns) Considerations Actions to take		
-		
Permissions Please initial the line to the l to stay and participate at Camp Blessing.	eft of each statement, then sign and date the bo	ttom. All campers must have authorization
I grant permission for any emergency treatmed camper listed above during his/her stay at Camp I Health Insurance Provider Group#		nent will be performed at a local hospital.
ID# Group#	Phone/approval #	
I grant permission for the nurse to administer counter medications such as Tylenol, Benadryl, c	medications prescribed by a physician, to treat ough drops, antacids, antibiotic ointment, topic	
tions on back.	articipate in all camp activities, including field t	rips off camp grounds. Please list excep-
Parent/Guardian		DATE



Medication Record Health Form 2013

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 cannot dispense medications unless:	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:	
Time to be given: Specific Instructions or Reason to contact Physician:	
Medication name:	
Dose and route:	
Time to be given:	
Time to be given: Specific Instructions or Reason to contact Physician:	
Medication name:	
Dose and route:	
Time to be given:	
Time to be given: Specific Instructions or Reason to contact Physician:	
Medication name:	
Dose and route:	
Time to be given:	
Time to be given:Specific Instructions or Reason to contact Physician:	
Physician/Practitioner's signature directs the abo	ove medication administration and indicates his/her willingness to
communicate with person who administers the medication. Name of Physician/Practitioner	
Address	Phone
CityStateZip	_
Physician/Practitioner Signature	Date
Parent/Guardian	DATE