

Wisconsin Crafting Retreat Application Form 2014

Since 1963 "an Experiment in Christian Living"

Retreat Name: Crafting Retreat March 13-15 **Retreat Dates: Retreat Directors:** Karen LePitre **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 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.

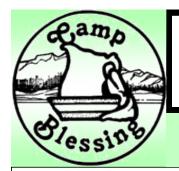


Medical Information & Health History Form 2014

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 Seizures Hypertension Epilepsy Bleeding Disorders	Ear Infections Heart Disease/defect Musculoskeletal Disorders Hay fever	Diabetes Asthma Skin Conditions Other	
Details			
General Diet: Spe	cial Diet:		
Allergies Please indicate all that apply Food Drug Animals Insect Bites Plant/pollens Other:	Symptoms to watch for Action to take		
Exceptions and Limitations Pleas emotional, or behavioral concerns) Considerations			
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 partitions on back.	cipate in all camp activities, including field tri	ps 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