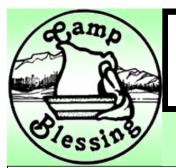
Ramp	Wisconsin Men's Retreat					
	Application Form 2014					
Clessing	Since 1963 "an Experiment in Christian Living"					
Retreat Name: Retreat Dates: Retreat Directors:	Men's Retreat April 4-6 Dennis Thorfeldt/Dic	ek Ostwald				
Camper Information Please complete a separate form for each person attending camp.						
		Camper Email				
		□Male □Female Grade Completed				
Emergency Contact Information Campers MUST have two emergency contacts to attend camp						
Contact #1						
		Relationship				
Address						
City	State Zip	Email				
Home Phone	Work Phone	Cell Phone				
Contact #2						
		Relationship				
Address						
City	StateZıp	Email				
Home Phone	Work Phone	Cell Phone				
Deadlines & Fees Applications should be received one month prior to camp/retreat start date. Camp Bless- ing reserves the right to cancel a camp/retreat if registration is inadequate. Retreat cost is \$25 for all partici- pants over 18 years ; please include payment with your application.						
Please return Wisconsin Applications and Forms to:						
Sara Lenzner						
822 N. 3 rd 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 2	014			
elessing Plea	ase include accurate health information that the Camp Director, St should be aware of to insure well-being of campers. All forms are available at <u>www.campblessing.com</u>	taff, and Nurse			
Medical record for (name)	Date:				
Health History Please check all that ap Seizures Hypertension Epilepsy Bleeding Disorders Details	Ear Infections Heart Disease/defect Musculoskeletal Disorders Hay fever	Diabetes Asthma Skin Conditions Other			
General Diet: S	Special Diet:				
Allergies Please indicate all that applyFoodDrugAnimalsInsect BitesPlant/pollensOther:	Symptoms to watch for Action to take				
Exceptions and Limitations PI emotional, or behavioral concerns) Considerations	lease list special considerations for this camper. (i.e. sleep disorde	er, bedwetting, physical,			
Actions to take					
to stay and participate at Camp Blessing. I grant permission for any emergency treatm camper listed above during his/her stay at Camp	left of each statement, then sign and date the bottom. All campers nents (including medical, surgical, anesthesia of other procedure) Blessing. It is understood that emergency treatment will be perfo	deemed necessary for the			
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 p tions on back.	participate in all camp activities, including field trips off camp gro	ounds. 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 will be kept secured in the Nurse's Office. 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

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:

Physician/Practitioner's signature directs the above medication administration and indicates his/her willingness to

communicate with person who administers the medication. Name of Physician/Practitioner

Address			F	hone
City	State	_Zip		
Physician/Practitioner Signature _			I	Date
Parent/Guardian				DATE