

Wisconsin Retreat Application Form 2014

Since 1963 "an Experiment in Christian Living"

Winter Family Retreat Retreat Name: January 31-February 2 **Retreat Dates: Retreat Directors: Todd and Jennifer Casell 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.

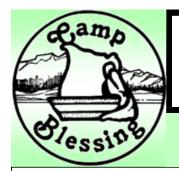


Medical Information & Health History Form 2014

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:		
Hypertension Hea	Infections Diabetes art Disease/defect Asthma sculoskeletal Disorders Skin Conditions by fever Other	S	
Details		_	
General Diet: Special Diet:			
Allergies Please indicate all that apply Food Drug	Symptoms to watch for	_	
Animals Insect Bites Plant/pollens Other:	Action to take	_ _ -	
Exceptions and Limitations Please list special considerations for this camper. (i.e. sleep disorder, bedwetting, physical, emotional, or behavioral concerns) Considerations			
Actions to take			
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.			
	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