Wisconsin Retreat Application Form 2014

Since 1963
"an Experiment in Christian Living"

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

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 _____

Emergency Contact Information

Campers 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 _____

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:_____ **Special 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 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.

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: _____
_____

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_____

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 _____ Phone _____

City_____ State____ Zip _____

Physician/Practitioner Signature _____ Date _____

Parent/Guardian_____ DATE_____