

Wisconsin Teen Retreat Application Form 2014

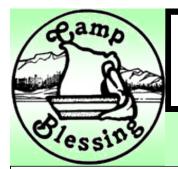
Since 1963 "an Experiment in Christian Living"

Retreat Name: Teen Retreat
Retreat Dates: February 14-17

Retreat Dates:	February 14-1	17			
Retreat Directors:	David and Tracie Elliott				
Camper Information	Please complete a separate	form for	r each person attending camp.		
Name of Camper					
	Phone				
			_ Camper Email		
Birth (MM/DD/YYYY)	Age (by start of camp)				
Emergency Contact l	Information Campe	ers MUST	T have two emergency contacts to attend camp		
Contact #1					
Name	Relationship				
Address					
City	State	Zip	Email		
	Work Phone Cell Phone				
Contact #2					
Name			Relationship		
Address					
City_	State	Zip	Email		
			Cell Phone		
	el a camp/retreat if reg	istration	one month prior to camp/retreat start date. Camp En is inadequate. Retreat cost is \$25 for all partic plication.		
Please return Wiscon	sin Applications	and F	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.

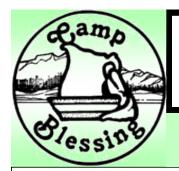


Medical Information & Health History Form 2014

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	Ear Infections	Diabetes	
Hypertension	Heart Disease/defect Asthma		
Epilepsy	Musculoskeletal Disorders Skin Conditions		
Bleeding Disorders	Hay fever Other		
Details			
General Diet:	Special Diet:		
Allergies Please indicate all that apply			
Food	Symptoms to watch for		
Drug			
Animals			
Insect Bites	Action to take		
Plant/pollens			
Other:			
Actions to take			
Permissions Please initial the line to the to stay and participate at Camp Blessing.	te left of each statement, then sign and date the bott	om. All campers must have authorization	
camper listed above during his/her stay at Cam	tments (including medical, surgical, anesthesia of on p Blessing. It is understood that emergency treatmed Phone/approval #	ent will be performed at a local hospital.	
ID# Group#	Phone/approval #		
	ster medications prescribed by a physician, to treat sl, cough drops, antacids, antibiotic ointment, topica		
tions on back.	participate in all camp activities, including field tr	ips 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