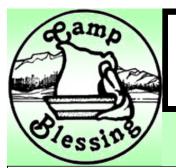
a amp	Wisconsin Women's Retreat				
E E	Application Form 2014				
Clessing	Since 1963 "an Experiment in Christian Living"				
Retreat Name: Retreat Dates: Retreat Directors:	Women's Retreat October 10-13 Kathy Polychronis				
	n Please complete a separate form for				
		Camper Email			
Birth (MM/DD/YYYY)	Age (by start of camp)	□Male □Female Grade Completed			
Emergency Contact	Information Campers MUST	have two emergency contacts to attend camp			
		Relationship			
Address					
City	State Zip	Email			
Home Phone	Work Phone	Cell Phone			
		Relationship			
Address	94-4- 7 :	Dave 1			
City	State Zip Work Phone	Email Cell Phone			
	work rhone				
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 Wisco	nsin Applications and Fo	orms 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.					

e amp	Medical Inform Health History F				
Please	include accurate health information that the or should be aware of to insure well-b All forms are available at <u>www.car</u>				
Medical record for (name)		Date:			
Hypertension Epilepsy Bleeding Disorders Details	Ear Infections Heart Disease/defect Musculoskeletal Disorders Hay fever	Diabetes Asthma Skin Conditions Other			
Diet:					
Allergies Please indicate all that apply Food Drug Animals Insect Bites Plant/pollens					
<u>Other:</u> <u>Exceptions and Limitations</u> Plea emotional, or behavioral concerns)		(i.e. sleep disorder, bedwetting, physical,			
Considerations					
Permissions Please initial the line to the le to stay and participate at Camp Blessing.	ft of each statement, then sign and date the bo	ttom. All campers must have authorization			
I grant permission for any emergency treatmer camper listed above during his/her stay at Camp B Health Insurance Provider ID# Group#	nts (including medical, surgical, anesthesia of lessing. It is understood that emergency treatm Phone/approval #	nent will be performed at a local hospital.			
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.	ticipate in all camp activities, including field	trips 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 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