

## Wisconsin Work Weekend Retreat **Application Form 2014**

### **Since 1963**

"an Experiment in Christian Living"

**Retreat Name: Work Weekend Retreat** June 11–14, 2014 **Retreat Dates: Retreat Directors: Todd 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 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:

822 N. 3<sup>rd</sup> 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.

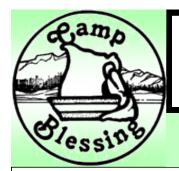


# Medical Information & Health History Form 2014

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		
	_ Ear Infections	Diabetes
Hypertension	_ Heart Disease/defect	Asthma
_ Epilepsy _	_ Musculoskeletal Disorders	Skin Conditions
Bleeding Disorders	_ Hay fever	Other
Details		
	iet:	
Allergies Please indicate all that apply		
Food	Symptoms to watch for	
Drug		
Animals		
Insect Bites	Action to take	
Plant/pollens		
Other:		
Exceptions and Limitations Please emotional, or behavioral concerns)  Considerations  Actions to take		
<b>Permissions</b> Please initial the line to the left to stay and participate at Camp Blessing.	of each statement, then sign and date the botto	m. All campers must have authorization
I grant permission for any emergency treatments camper listed above during his/her stay at Camp Ble Health Insurance Provider_	ssing. It is understood that emergency treatmer	
ID# Group#	Phone/approval #	
I grant permission for the nurse to administer modulate medications such as Tylenol, Benadryl, coug		
The camper listed above has permission to partitions on back.	cipate in all camp activities, including field trip	os 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:	<del></del>
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:	<del></del>
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