



# Wisconsin Retreat Application 2024 (Form A)

**Retreat Name/Dates:** Spring/Fall Craft Retreat, March 15–23 and September TBD  
**Retreat Directors:** Karen LePitre

## Camper Information

 Please complete a separate form for each person attending camp.

Name of Camper \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Camper Email \_\_\_\_\_  
Birth (MM/DD/YYYY) \_\_\_\_\_ Age (by start of camp) \_\_\_\_\_  Male  Female

## 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 \_\_\_\_\_

Please return Wisconsin Applications and Forms to: [CampBlessingApps@gmail.com](mailto:CampBlessingApps@gmail.com) or  
Marcia Graveen 1650 Naugart Dr. Merrill, WI 54452

**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 the weekend only or \$125 for the week for all participants over 18 years**; please include payment with your application.

## Assumption of Risk / Waiver of Liability / Indemnification Agreement

In consideration of being allowed to participate on behalf of Camp Blessing, Inc. and related events and activities, the undersigned acknowledges, appreciates, and agrees that:

1. Participation includes possible exposure to and illness from infectious diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and,
2. I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the releases or others, and assume full responsibility for my participation; and,
3. I willingly agree to comply with the stated terms and conditions for participation as regards to protection against infectious diseases; and,
4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Camp Blessing, Inc., their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event (“RELEASEES”), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

Camper's Signature \_\_\_\_\_ Date \_\_\_\_\_



# Medical Information & Health History 2024 (Form B)

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](http://www.campblessing.com)

Medical record for (name) \_\_\_\_\_ Date: \_\_\_\_\_

## Health History

Please check all that apply

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Ear Infections            | <input type="checkbox"/> Diabetes        |
| <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Heart Disease/defect      | <input type="checkbox"/> Asthma          |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hay fever                 | <input type="checkbox"/> Other           |

Details \_\_\_\_\_

General Diet: \_\_\_\_\_ Special Diet: \_\_\_\_\_

## Allergies

Please indicate all that apply

- |  |                      |
|--|----------------------|
| <input type="checkbox"/> Food          | List Allergens _____ |
| <input type="checkbox"/> Drug          | _____                |
| <input type="checkbox"/> Animals       | _____                |
| <input type="checkbox"/> Insect Bites  | Symptoms _____       |
| <input type="checkbox"/> Plant/pollens | _____                |
| <input type="checkbox"/> Other: _____  | Actions _____        |

## 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 sign and date the bottom. All campers must have authorization to stay and participate at Camp Blessing. By attending a Camp Blessing event, you grant permission to use photos of attendee in Camp Blessing publication such as , but not limited to brochures, web sites and camp reports.

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 included but not limited to analgesics (pain reliever) antihistamines, 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.

Camper Signature \_\_\_\_\_ Date \_\_\_\_\_



# Medication Record Health 2024 (Form C)

**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.

**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: \_\_\_\_\_

Specific instructions or reason to contact physician: \_\_\_\_\_

**Medication name:** \_\_\_\_\_

Dose and route: \_\_\_\_\_

Time to be given: \_\_\_\_\_

Specific instructions or reason to contact physician: \_\_\_\_\_

**Camper Signature** \_\_\_\_\_ **DATE** \_\_\_\_\_