



# Wisconsin Camp Application Form 2025 (Form A)

- Kid's Camp July 13-18 — Katie Turnbow and Levi Schultz  
 Teen Camp July 20-26 — Larry Iannaccone  
 Special Person's Camp July 28-Aug 4 — Todd Casell and Sarah Roehr

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

## Parent/Guardian and Emergency Contact Info

Campers MUST have two contacts to attend camp

### Parents/Guardians (Emergency Contact #1)

Name(s) \_\_\_\_\_ Relationship(s) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Emergency Contact #2

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Please scan and email or mail forms to:

Marcia Graveen 1650 Naugart Dr. Merrill, WI 54452 [CampBlessingApps@gmail.com](mailto:CampBlessingApps@gmail.com)

**Deadlines** 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.

Camp Blessing reserves the right to accept or deny camp applications

### 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.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



# Medical Information & Health History Form 2025 (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.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



# Medication Record Health Form 2025 (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:** \_\_\_\_\_

Reason: \_\_\_\_\_

Dose, Route, and Time: \_\_\_\_\_

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

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

Reason: \_\_\_\_\_

Dose, Route, and Time: \_\_\_\_\_

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

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

Reason: \_\_\_\_\_

Dose, Route, and Time: \_\_\_\_\_

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

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

Reason: \_\_\_\_\_

Dose, Route, and Time: \_\_\_\_\_

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

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

Reason: \_\_\_\_\_

Dose, Route, and Time: \_\_\_\_\_

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

**Parent/Guardian Signature** \_\_\_\_\_ **DATE** \_\_\_\_\_



**PHYSICAL EXAM FORM – CAMP BLESSING (Form D)**  
**To be completed and signed by your MD/PA/NP**  
Campers must have PHYSICAL EXAM FORM completed within the past 24 months. It is to be on file at Camp Blessing.

Name of Camper/Staff: \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Date of Exam \_\_\_\_\_

**IMMUNIZATIONS:** This person has been immunized in accordance with the recommended immunization schedule appropriate for his/her age as approved by the CDC and the American Academy of Pediatrics.

Yes  No

Immunizations have been declined by parents for religious or medical reasons.

Date of last Tetanus \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Please attach a copy of complete immunization record to this form.

**Examination:**

Essential findings \_\_\_\_\_

Health problems that camp should be aware of \_\_\_\_\_

Please explain what to watch for \_\_\_\_\_

Identify any health risks ( i.e. allergies, etc.)

\_\_\_\_\_

Action to take \_\_\_\_\_

Medical devices bringing to camp (Such as wheelchair, walker, cane, C-Pap): \_\_\_\_\_

Recommendations for restriction of physical activity at camp.

None  Yes

Explain \_\_\_\_\_

\_\_\_\_\_

**Medications:** If this camper is currently taking medication to be given while attending camp, please list them on and sign the Medications Form.

In my opinion, this person's condition allows participation in an active camp program.

Signature of MD/PA/NP \_\_\_\_\_

Printed Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Date \_\_\_\_\_

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