WINTER RETREAT 2019

FOR STUDENTS IN 6TH-8TH GRADE

SCHEDULE – February 15-17

Drop Off – 5:30PM Friday, February 15th at Jacob's Well.

*****IMPORTANT***** Make sure to eat dinner before coming to church, we will not have a meal provided on Friday night.

Pick Up – 5:00PM Sunday February 16th at Jacob's Well.

CAMP LOCATION & CONTACT PERSON

Expeditions Unlimited – E11844 County Rd DL Baraboo, WI 53913

If there is an emergency or you have an urgent need to reach a staff member while we are on the retreat, please call **Joshua Skoyen at (715) 533-3620 or Jordan Hurlburt at (715) 495-8067**.

WHAT TO BRING

• SLEEPING BAG	• BIBLE
• PILLOW	• NOTEBOOK / JOURNAL
• TOOTHBRUSH	• PENS
• TOOTHPASTE	• TOWEL
• SHAMPOO / CONDITIONER	• SOCKS – extra socks never hurts
• BODY WASH	• SHOES / BOOTS
• DEODORANT – yes, all of you	• CLOTHING FOR 3 DAYS
• GLASSES / CONTACTS/ SOLUTION	• WARM CLOTHING / JACKET, GLOVES, HAT
• HAIR STUFF	• PAJAMAS
• MEDICATIONS	• EXTRA MONEY FOR THE CAFÉ

WHAT **NOT** TO BRING

- CELLPHONE, IPOD, TABLET, LAPTOP OR ANY OTHER ELECTRONIC DEVICE
- KNIVES OR ANYTHING THAT LOOKS LIKE A WEAPON

COST - $170

Checks can be written out to Jacob's Well

There are plenty of free things to do at camp! You don't need to bring spending money, however, there is a great café with snacks and Expeditions swag.

*****CANCELLATIONS -** We will offer a partial refund after February 1st. ($100 of the camp fee will be non-refundable past that date.)

REMEMBER

// You will not be allowed to go on the trip unless we have forms and full payment. //

// Payment Plans are available upon request. Please email jhurlburt@jacobswellchurch.church //

FORMS AND PAYMENT ARE DUE JANUARY 23RD

CONSENT AND RELEASE FORM

Name of Participant: _____ DOB: _____ Grade: _____ Gender: _____

Primary Contact Name: _____ Primary Contact Phone: _____

Home Contact Address: _____

Emergency Backup Contact *(different from above):* _____
Name, Number

Dietary Preference: ☐ Vegetarian ☐ Vegan ☐ Gluten-Free Other: _____

T-Shirt Size: _____

For Overnight Events - Choose up to 3 friends you would like to have in your cabin. We guarantee you will be with at least 1 of them.

1. _____ 2. _____ 3. _____

NOTE TO PARTICIPANTS/PARENTS-GUARDIANS:

Jacob's Well wants you and your child to have a safe and healthy experience. However, in the event of an accident or illness, it is important that we have the following information.

Any allergies or other medical needs? _____

Limits to activities: _____

Name of Physician: _____ Physician Phone: _____

Medical Insurance Company: _____ Policy Number: _____

I understand that my student will be riding in a vehicle with a qualified youth leader.

INDEMNITY AND CONTACT AGREEMENT:
I will not hold or attempt to hold Jacob's Well liable for any loss, damage or injury to person or property caused by any act or neglect of other persons, or caused in any manner other than the willful or negligent act of Jacob's Well, its agents and employees, and will indemnify and hold Jacob's Well harmless from any liability for damages or claims against Jacob's Well arising out of, or in any way related to any such loss, damage, or injury.

I release Jacob's Well, including its trustees, employees, and agents, from my child's or my own physical injury, including death, or illness while at the activity. I/We will assume the risk associated therewith, whether known or unknown to me/us at this time. This release is also intended to include all claims of my family, estate, heirs, personal representatives or assigns.

AUTHORIZATION FOR TREATMENT:
In the event that I cannot be reached, I/We hereby give permission to the medical personnel selected by Jacob's Well to secure and administer treatment and to maintain and/or release any medical records necessary for insurance purposes as outlined under the HIPAA regulation, and to provide or arrange necessary related transportation for the above named person.

I verify that I, or child named above, is in good health and capable of participating in strenuous activities and, when necessary, will tailor my/their activities to those within the bounds of my/their physical health.

I recognize that any medical treatment that is provided to me or my child while attending a Jacob's Well activity will be paid for by my medical insurance company and guarantee payment for services not paid by insurance.

I hereby grant Jacob's Well permission to use, reproduce, and/or distribute photographs, films, video, and sound recordings of my child or I without compensation or approval, for use in materials created for purposes of promoting the activities of Jacob's Well, including the internet.

Signature: _____ Date: _____

JSTUDENTS

CAMP HEALTH EXAMINATION FORM

Developed by the American Camping Association in consultation with The American Medical Association and the American Academy of Pediatrics

Name:_____ **Birth date:** _____**Gender: M:**___**F:**___ **Age:**_____
Last First M. Init.

Name of Parents/Guardians
(or spouse): _____**Phone:** _____

Home Address:_____
Street City State Zip

Email Address:_____

Church: _____
If not available in an emergency please notify:

1. _____Phone: _____
   Name Relationship
2. _____Phone: _____
   Name Relationship

Check all that apply, giving approximate dates

Health History	Date	Allergies	Date	Diseases	Date
____ Frequent Ear Infections	_____	____ Hay Fever	_____	____ Chicken Pox	_____
____ Heart Defect/Disease	_____	____ Poison Ivy, etc.	_____	____ Measles	_____
____ Convulsions	_____	____ Insect Stings	_____	____ German Measles	_____
____ Diabetes	_____	____ Penicillin	_____	____ Mumps	_____
____ Bleeding/Clotting Disorders	_____	____ Other Drugs	_____	____ Asthma	_____

Allergies (describe reactions/treatment):
_____

Operations or serious injuries and dates:
_____

Chronic or recurring illnesses:
_____

Dentist/Orthodontist: _____Phone: _____
Family Doctor: _____ Phone: _____
Medical/Health Insurance Company:_____**Policy or Group #:**_____
IMPORTANT: *Please notify us if this individual is exposed to any communicable disease during the three weeks prior to attending.*

Medications: ***All medications must be in original pill bottles!***

Medication 1: Dosage: Administer at: ☐breakfast ☐lunch (Check all that apply) ☐dinner ☐bed ☐other Reactions:

Physician: RX#: Route of Administration: Date:

Medication 2: Dosage: Administer at: ☐breakfast ☐lunch (Check all that apply) ☐dinner ☐bed ☐other Reactions:

Physician: RX#: Route of Administration: Date:

(If more medications are necessary please use the back of this form)

IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE

Parental Authorization. This health history is correct so far as I know, and the person described herein has permission to engage in all prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Expeditions Unlimited staff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I also give permission to the physician selected by the Expeditions Unlimited staff to hospitalize, secure proper treatment for, to order injection and/or anesthesia and/or surgery for my child as named above.

Parental Signature:_____ **Date:**_____

Release of Claims and Waiver of Liability

The undersigned applicant acknowledges, understands and agrees that as to the contemplated trip with Expeditions Unlimited:

1. There are unique physical demands and risks involved;
2. The activity can be of a dangerous nature which can result in serious and potentially fatal injury;
3. That instructions given must be followed for ongoing participation and safety of the applicant; and
4. That Expeditions Unlimited, Ltd. retains the right of final approval of all participants and the right to terminate a participant's involvement in a trip at its discretion.

In consideration of conducting the trip and based on the above, Expeditions Unlimited, Ltd., it's officers, directors, shareholders, employees, agents and their heirs, executors and assigns are released as to any and all claims for damages, including but not limited to injuries, whether to person or property, known or unknown that the undersigned has or may have in the future arising out of and in connection with the contemplated trip.

Release as to Photographic, Movie and Video Images
The undersigned irrevocably consents to and authorizes the use and reproduction of any and all photographic and video images taken during the contemplated trip. The use and reproduction of images is at the discretion of Expeditions Unlimited whether for advertising, promotional or other legal purposes without additional consideration or compensation to the undersigned. Originals and copies or images are and will remain the sole property of Expeditions Unlimited, Ltd.

Applicant Information
Complete the following information for each member of your household participating in the trip with Expeditions Unlimited.

Name(s)

Address

City State Zip

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Parent or Guardian Signature _____Date____/____/____
*Required if applicant is under 18 years of age

E11844 County Road DL
Baraboo, WI 53913

Telephone (608) 356-4004
Fax (608) 356-4185

Food Allergy Action Plan

*Completion of this form is necessary **only** if participant has a food allergy*

Name: _____

Group: _____

Allergy To: ☐ Dairy ☐ Wheat ☐ Eggs ☐ Peanuts ☐ Tree Nuts ☐ Other: (Please list)

_____

Physician: _____ Phone #: _____

Emergency Numbers
Name: _____ Phone #: _____

Name: _____ Phone #: _____

PLEASE TELL US WHAT TO DO IN CASE OF AN ALLERGIC REACTION
CHECK ALL THAT APPLY

This Occurs:
My Child's allergic reaction includes:

- ☐ Swelling, itching raised skin rash
- ☐ Generalized body flush, swelling or itching
- ☐ Nausea, abdominal cramps, vomiting and/or diarrhea
- ☐ Itching and swelling of lips, throat, or tongue causing hoarseness, swallowing difficulty, coughing, wheezing or shortness of breath.
- ☐ "Thready" pulse, "passing out"
  - These signs may occur
    - ☐ Within a few minutes
    - ☐ Within 30 minutes to 2 hours

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation.

General First Aid

- Observe for 30 minutes
- Notify Parents
- ☐ Administer oral medication And
  Name _____ _____
  Dosage _____ _____
- ☐ Administer adrenaline (Epi Pen)
  - ☐ Immediately
- ☐ If symptoms occur (describe)

Student can self-administer Epi Pen? Yes No

If Epi pen is administered, an ambulance, then parents will be notified

** ***Please Note**: Expeditions Unlimited **cannot** provide specialized meals for participants but we can provide a couple of additional options, as well as inform students of the ingredients found in prepared food.*

Please return this form **2 weeks** prior to scheduled arrival date.
If returned later than **2 weeks** additional options may not be available.

Comments regarding other accommodations: _____

Parental Signature: _____ Date: _____