



**Camp Good Grief Registration Form**  
**Registration Deadline: Monday, April 18, 2022**

Please mail or fax to:

Compassus Bethany House/Camp Good Grief  
1171 Gatewood Dr. Bldg. 100, Auburn AL 36830  
Fax: 334-826-0756

**\*Please include a picture of your child for counselor reference.**

Camper's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female  
T-shirt size:  Youth S  Youth M  Youth L  Youth XL  Adult S  Adult M  Adult L  Adult XL  Adult 2X  
Home Address: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Grade: \_\_\_\_\_ School: \_\_\_\_\_

My Camper is attending Camp Good Grief in memory of:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of death: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Cause of death? \_\_\_\_\_ Was the death expected or unexpected? \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of death? \_\_\_\_\_  
Cause of death? \_\_\_\_\_ Was the death expected or unexpected? \_\_\_\_\_

Use the following space to describe any changes in your child's thoughts, feelings or behaviors you have noticed since the death. If more space is needed, please continue on the back. \_\_\_\_\_

Is your child a first time camper at Camp Good Grief?  Yes  No If not, list previous years attended. \_\_\_\_\_

Please list any siblings who are also attending camp this year. \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
E-mail: \_\_\_\_\_

I give Camp Good Grief, Compassus, Compassus Living Foundation, and Hospice Angels Foundation staffs permission to photograph, video and/or interview me or my child and to use these images, recordings and/or quotes to train staff and to promote the camp via brochures and other means of publication.

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

**Camp Good Grief Medical Consent Form**

I, \_\_\_\_\_, guardian of \_\_\_\_\_, give my consent for the camp nurse to render necessary first aid in the event of accident or sickness.

In case of emergency, notify:

Name: \_\_\_\_\_ Primary Phone Number : (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Additional Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

In the event of an emergency, I do hereby authorize Camp Good Grief, Compassus, Compassus Living Foundation, and Hospice Angels Foundation to provide emergency treatment to my child. In the event that the appropriate treatment cannot be provided at the campsite, I consent to for my child to be taken to EAMC emergency department where the physician will exercise his/her best judgment as to the diagnosis and treatment. I further consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered. I understand that should the need for medical care arise, I will be financially responsible for all costs incurred in rendering or providing medical attention to my child and Camp Good Grief, Compassus, Compassus Living Foundation, and Hospice Angels Foundation is not obligated to provide insurance nor will it assume financial responsibility for medical assistance provided.

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

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

**Name of medication:** \_\_\_\_\_ \*All medications should be given to the camp nurse, with the label on the bottle.

Time medication is to be given: \_\_\_\_\_ Dose to be given: \_\_\_\_\_ Time medication is to be given: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Route medication is to be given: \_\_\_\_\_

Medications to be administered by the camp nurse: \_\_\_\_\_