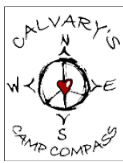

Calvary Camp Compass® August 11–15, 2025
Application and Registration Form

Where Life Continues

Thank you for your interest in Calvary's Camp Compass® 2025. This form is to be completed by a parent or legal guardian. You may complete this form electronically or by hand. If completing electronically, save the form to your device and email it to Jacqueline Marlow at jmarlow@calvaryhospital.org, or print it and fax it to 718-518-2552. You may also send it by mail: *Calvary Hospital's Bereavement Department, 1740 Eastchester Road, Bronx, NY 10471.* **Please complete all the information (one form per child) and sign all acknowledgements and authorizations where indicated.**

NOTE: If your child is new to Camp Compass® he or she will be required to attend an interview and attend a pre-camp workshop/orientation **prior to July 30, 2025.**

☐ If you a receiving help completing this form from a school counsellor or another person, please identify the person **here**.

NAME	PHONE NUMBER	EMAIL ADDRESS

A. Child's Information

CHILD'S NAME	CHILD'S DATE OF BIRTH	CHILD'S AGE

B. Clothes

Campers are provided with two (2) Camp Compass® t-shirts, a sweatshirt, and more! Please indicate sizes here.

T-shirt select one size only:

☐ T-Shirt **Child's Medium**	☐ T-Shirt **Child's Large**	☐ T-Shirt **Adult Small**	☐ T-Shirt **Adult Med.**	☐ T-Shirt **Adult Large**	☐ T-Shirt **X-Large**

Sweatshirt select one size only:

☐ SW **Child's Medium**	☐ SW **Child's Large**	☐ SW **Adult Small**	☐ SW **Adult Med.**	☐ SW **Adult Large**	☐ SW **X-Large**

C. Family Information

NAME OF PARENT/ LEGAL GUARDIAN	NON-CUSTODIAL PARENT
OTHER	RELATIONSHIP TO CHILD
HOME PHONE	☐ PREFERRED
WORK PHONE	☐ PREFERRED
CELL PHONE	☐ PREFERRED

STREET ADDRESS	CITY	STATE	ZIP CODE
EMAIL			

BROTHER(S)? LIST AGES:	SISTER(S)? LIST AGES:

Others living in the household and their relationship to the child:

1. NAME	RELATIONSHIP TO THE CHILD
2. NAME	RELATIONSHIP TO THE CHILD
3. NAME	RELATIONSHIP TO THE CHILD

CONTINUED

List name(s) of who died and when (date of death). *This information will assist counselors and will remain confidential.*

1. NAME OF DECEASED	DATE OF DEATH	RELATIONSHIP TO THE CHILD

CAUSE OF DEATH	Does the child know the cause of death? ☐ YES or ☐ NO. If no, please follow up with counsellor.

2. NAME OF DECEASED	DATE OF DEATH	RELATIONSHIP TO THE CHILD

CAUSE OF DEATH	Does the child know the cause of death? ☐ YES or ☐ NO. If no, please follow up with counsellor.

Express your view of how you think your child is reacting to the death(s):

D. Emergency Contacts + Medical Information

Complete this information yourself. There is no requirement for a Physician or health care provider to complete this section.

EMERGENCY CONTACT **OTHER THAN YOURSELF**	RELATIONSHIP OF EMERGENCY CONTACT TO YOUR CHILD
EMERGENCY CONTACT HOME PHONE	☐ PREFERRED
EMERGENCY CONTACT WORK PHONE	☐ PREFERRED
EMERGENCY CONTACT CELL PHONE	☐ PREFERRED
CHILD'S PHYSICIAN	CHILD'S PHYSICIAN PHONE

CHILD'S PHYSICIAN STREET ADDRESS	CITY	STATE	ZIP CODE

Do you have medical/hospital insurance? ☐ **YES** ☐ **NO**

DATE OF CHILD'S LAST PHYSICAL EXAM *Must be within the last 24 months*	DATE OF CHILD'S LAST TETANUS SHOT

Proof of Immunization: *Please provide* ***date*** *of immunization from your Health Care Provider of the following vaccinations.*

MEASLES Date	RUBELLA Date	MUMPS Date	VARICELLA Date

HEALTH ISSUES AND ALLERGIES

Does your child have **any** health problems that we need to be aware of? ☐ **YES,** as described below or ☐ **NO.** If no, skip to Acknowledgment.

☐ **YES, ALLERGIES TO:** *Please tick all boxes that apply and explain.*

☐ MEDICATION> Please specify ____________________

☐ FOOD> Please specify ____________________

☐ BEES/INSECTS> Please specify bug and treatment ____________________

☐ OTHER> Please identify ____________________

Other information: *Answer all questions.*

Has your child ever been stung by a bee? ☐ YES ☐ NO

Is your child diabetic? ☐ YES ☐ NO

Does your child get car sick? ☐ YES ☐ NO

Has your child ever had a seizure? ☐ YES ☐ NO

Can your child swim? ☐ YES ☐ NO

Is your child presently taking medication? ☐ **YES,** name of medicine ____________________ ☐ **NO**

If yes, for what purpose?____________________ Dosage? __________ Frequency ____________

If your child needs to be administered medication at camp, you **must** provide a *Physician's Order and a permission note.*
All medication(s) must be in the original container.

Acknowledgement

☐ I will discuss my child's medical and health needs with the camp director [insert title here], understanding that this information is necessary to ensure my child's health and safety while attending camp. I acknowledge that any discussion may include sensitive health information, and I consent to sharing such details for the sole purpose of providing appropriate care and support for my child during their camp experience.

NAME OF PARENT/ LEGAL GUARDIAN	SIGNATURE OF PARENT/ LEGAL GUARDIAN	DATE

By typing my name above, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature

CONTINUED

E. Authorization to Treat a Minor

I (we) the undersigned parents or legal guardian of: CHILD'S NAME

in case of emergency, give permission to the physician or registered nurse/paramedic/EMT selected by the Camp Compass® Staff to hospitalize and/or provide such care, order injections, and administer such diagnostic, radiological, pathological, surgical, anesthesia, and/or therapeutic procedures and treatment as deemed necessary or advisable by a responsible medical professional.

As parent or legal guardian of the applicant, I am in favor of my child attending camp functions and accept the conditions named. The heath history is correct as far as I know, and the person herein described has permission to engage in all prescribed Camp activities except as noted. In addition, I have read and understand this Authorization Form and give my full consent to the terms found herein. Permission for photocopying this health record is granted.

NAME OF PARENT/ LEGAL GUARDIAN	**SIGNATURE** OF PARENT/ LEGAL GUARDIAN	DATE

By typing my name above, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature

F. Authorization to Administer Medicine

I (we) the undersigned parents or legal guardian of: CHILD'S NAME

give permission to the registered nurse/paramedic/EMT selected by the Camp Compass® Staff to administer Tylenol, Midol, or Advil to my child. I give permission form my child to bring to camp and apply his or her own sunscreen or permission for a counselor to apply the sunscreen.

NAME OF PARENT/ LEGAL GUARDIAN	**SIGNATURE** OF PARENT/ LEGAL GUARDIAN	DATE

By typing my name above, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature

G. Authorization to Participate in Camp

I grant permission for the applicant to participate in all planned camp activities. I hereby grant Camp Compass® of Calvary Hospital and its agents' full authority to take whatever action they deem necessary regarding my child's health and safety, and I fully release Camp Compass® of Calvary Hospital from any liability in connection there within. In the event of an emergency, I understand that prudent attempts will be made to contact the undersigned immediately. I understand that I will be responsible for payment of all medical and medication bills. I individually and corporately agree to hold harmless Camp Compass® of Calvary Hospital, its volunteers, agents, employees and officers irrespective of any negligent act or omission by Camp Compass® of Calvary Hospital and or those individuals arising from or related in any way to this Camp Compass® of Calvary Hospital.

NAME OF PARENT/ LEGAL GUARDIAN	**SIGNATURE** OF PARENT/ LEGAL GUARDIAN	DATE

By typing my name above, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature

H. Media Release Authorization

I, NAME the undersigned ☐ parent or ☐ legal guardian of:

CHILD'S NAME do hereby consent to the photography, audiotaping, and videotaping of:

CHILD'S NAME during camp week August 11-15, 2025, for marketing and education

purposes related to Calvary Hospital and Calvary's Camp Compass®:

- These photos and videos may be used on Calvary's website, brochures, as well as social media platforms such as Facebook, LinkedIn, Instagram, and X/Twitter.
- Your child will not be identified by name in any photo or video.
- I waive all claims for any compensation for such use.
- There is no expiration to this signed and dated media release form.

NAME OF PARENT/ LEGAL GUARDIAN	**SIGNATURE** OF PARENT/ LEGAL GUARDIAN	DATE

By typing my name above, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature

CONTINUED

I. Transportation Registration

Transportation for Camp Compass® will be provided for your child/children. Your child/children can be dropped off and picked up every day at the locations listed below OR you may drop off and pick up your child every day directly at the camp's location: **Queensborough Community College, 222-05 56th Avenue, Bayside, New York 11364.**

If you're leaving from the **Bronx** or **Brooklyn** locations, your child must be **dropped off by 7:30am** and **picked up at 4pm.**
If you are going directly to **Queensborough Community College,** your child must be **dropped off at 8:45am** and **picked up at 2:45pm.**

CHILD'S NAME

Preferred Mode of Transportation. *You must select one only:*

☐ **Bronx Bus:** I will drop off (by 7:30am) and pick up (at 4:00pm) my child at **Calvary Hospital at 1740 Eastchester Road, Bronx, NY 10461**

☐ **Brooklyn Bus:** I will drop off (by 7:30am) and pick up (at 4:00pm) my child at **The Brooklyn Hospital Center 121 DeKalb Avenue, Brooklyn, NY 11201**

☐ **Personal Transportation:** I will drop off (at 8:45am) and pick up (at 2:45pm) my child at **Queensborough Community College, 222-05 56th Avenue, Bayside, New York 11364**

Authorized Person(s) to Drop-off and Pick-up Child. *You may authorize more than one person.*

FIRST NAME AND LAST NAME | DATE OF BIRTH

RELATIONSHIP TO CAMPER ☐ MOTHER ☐ FATHER ☐ GUARDIAN ☐ OTHER CUSTODIAL PARENT

EMAIL ADDRESS | OCCUPATION

HOME PHONE ☐ PREFERRED

WORK PHONE ☐ PREFERRED

CELL PHONE ☐ PREFERRED

STREET ADDRESS | CITY | STATE | ZIP CODE

FIRST NAME AND LAST NAME | DATE OF BIRTH

RELATIONSHIP TO CAMPER ☐ MOTHER ☐ FATHER ☐ GUARDIAN ☐ OTHER CUSTODIAL PARENT

EMAIL ADDRESS | OCCUPATION

HOME PHONE ☐ PREFERRED

WORK PHONE ☐ PREFERRED

CELL PHONE ☐ PREFERRED

STREET ADDRESS | CITY | STATE | ZIP CODE

J. Transportation Waiver, Release, and Authorization

As a service to Camp Compass participants and their families, Calvary Hospital has contracted and/or arranged to transport campers to and from camp Queensborough Community College, 222-05 56th Avenue, Bayside, New York 11364. This transportation service is provided as a courtesy and is purely voluntary. If a camper is to use this transportation, a parent or guardian must sign this Waiver, Release and Authorization which confirms that he/she agrees that Calvary Hospital is not responsible if his/her student is injured while using the bus service.

I understand that my child is not required to use the transportation service provided to Camp Compass participants. I choose to participate voluntarily and in my sole discretion without any influence by Calvary Hospital. I assume all risk for injuries or damages, which may arise in connection with this transportation service to my child.

I hereby give consent for my child to participate in the use of the transportation service provided to Camp Compass participants. To the maximum extent permitted by law, I hereby agree to release and hold harmless Calvary Hospital, Inc., its parents and affiliates, and their respective trustees, directors, officers, employees, servants and volunteers (hereinafter referred to as "Releases") from any and all responsibility, liability, claims and/or demands arising out of my child's participation, specifically including any injury that may occur due to their negligence.

I represent that my child does not have an undisclosed medical condition that prevents his or her participation in using the transportation service provided to Camp Compass participants. In the event that I cannot be reached in an emergency, I give permission to the physician selected by Calvary Hospital and Camp Compass to secure and administer treatment, including hospitalization, for the above-named child. I also understand and agree to abide by any restrictions placed on my or my child's participation, and that I and/or my child will be dismissed if we fail to abide by the program rules.

☐ I have reviewed this document and understand its contents and am signing voluntarily and of my own free will. By typing my name below, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature

NAME OF PARENT/ LEGAL GUARDIAN | **SIGNATURE** OF PARENT/ LEGAL GUARDIAN | DATE

This completes the form. Thank you. Please SAVE this PDF to your device and email it to jmarlow@calvaryhospital.org