

**APPLICATION FORM**

**FALL GRIEF CAMP – NOVEMBER 22, 2025**

**CHILDREN'S GRIEF CAMP**

**P.O. Box 453**

**Galesburg, IL 61402-0453**

**Phone: (309) 368-3563**

**Instructions:** Please complete all information asked for on this form. Students, be sure to have your parent or guardian sign the Consent and Release Section as well. When your application form is complete, please return the application to Children's Grief Camp.

Name (Please print clearly): \_\_\_\_\_  
First Last

Mailing Address: \_\_\_\_\_  
Street, P.O. Box, Etc.

\_\_\_\_\_  
City/Town State Zip Code

Home Phone: ( ) E-Mail: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

School you attend: \_\_\_\_\_ Grade: \_\_\_\_\_

Please note that masks are optional at this time, subject to change in the future per CDC guidelines. Masks will be available if any participant chooses to wear one.

**Health History**

Family Physician or Family Clinic \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Do you have insurance coverage for the Participant named above? Yes \_\_\_\_\_ No \_\_\_\_\_

Insurance Carrier (Name, Address & Phone Number) ( ) \_\_\_\_\_

Person to call in an emergency: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**(OVER)**



**CONSENT & RELEASE FORM**

(To be signed by the person legally responsible)

**Consent for Attendance (Name of Participant):** \_\_\_\_\_

I hereby give permission for the participant named above to attend the Grief Camp at:  
Carl Sandburg College, Building B, Galesburg, Illinois on November 22, 2025.

**Initial for Approval:** \_\_\_\_\_

**Medical Consent:**

I understand that some programs are conducted in an outdoor setting. I hereby authorize appropriately trained staff or camp personnel, or other medical personnel designated, to administer first-aid treatment to the participant if necessary. In the event that the participant suffers a serious injury or illness, I understand that I will be notified as soon as possible to obtain my approval for treatment. In the event that efforts to contact me are unsuccessful or are not possible during emergency circumstances, I hereby authorize the attending physician to administer any treatment including surgery which he or she deems necessary. I understand that I will, in any event, be contacted as soon as possible.

**Initial for Approval:** \_\_\_\_\_

**Payment for Medical Treatment:**

I agree to be responsible for paying any medical bills, either directly or through insurance payments that may result for any treatment deemed necessary by medical personnel.

**Initial for Approval:** \_\_\_\_\_

**Release of Liability:**

For and in consideration of the Participant in the Grief Camp, I hereby release and hold harmless Children's Grief Camp, a non-profit corporation; their officers; employees, volunteers or agents; and any medical personnel they select, from any and all liability or damages including accidental injury or illness which may occur during the Participant's attendance at the Grief Camp.

**Initial for Approval:** \_\_\_\_\_

**NAME of Participant (please print)** \_\_\_\_\_

\_\_\_\_\_  
Address City State Zip Code

( ) ( ) ( )  
Home Phone Work Phone Cell Phone

\_\_\_\_\_  
Signature of Parent or Guardian