2026 Camp Calvary Adventure Camp Retreat
Camper Registration

Space is limited for each retreat so please register early. Please rank, 1st-3rd choice, the order you prefer to order. If you choose a weekend that is already full, we will contact you and work out another date. Confirmations will be mailed after registration is received. There is a 30-camper limit per weekend, 15 male and 15 female.

The cost for EACH retreat is $116 which includes a t-shirt, group picture and buddy picture.

_____March 27-29 – Donna Shryock
_____August 14-16 – Mark & Jane Redmon
_____Sept/Oct (date to TBD) – TBD

Due to high volume of camper interest, we ask that you rank the weeks(1st to 3rd), in the order that you would like to attend. For any question, contact Camp Calvary (859)375-4376

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Please fill out this form completely! If the information requested is not applicable, simply place "N/A" in the blank. If, during the admissions process, it is determined that the information provided is not adequate for the necessary care of the camper, the camper may miss an opportunity to attend the session they desire. **A camper's opportunity to attend is based upon the information provided and availability of staff to meet care requirements.**

Last Name_____ First Name_____ Gender: M F

Date of Birth_____ Age_____ Height_____ Weight_____

Shirt Size: Sm. Med. L. XL 2X 3X 4X

Primary Contact Information (Parent, social worker or agency representative) The person who we would call if additional information in needed or in case of an emergency a member needed to be picked up**:**

Contact and/or Facility Name: _____Phone:_____

Address _____City_____State/Zip_____

Primary Contact or Person Submitting this Form's Name:_____

Work Phone (_____) _____ Alt. Phone (_____)_____

Parent/Guardian/Caretaker_____

Address_____City_____State/Zip_____

Home Phone (_____)_____ Alt. Phone (_____)_____

Email to send camp information to:_____

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Emergency Contacts

Please provide at least one emergency contact person in the event that we cannot reach the Primary Caregiver.

1. Name_____ Phone (____)_____Alt. (____)_____

Address_____Relationship to Camper_____

2. Name_____ Phone (____)_____Alt. (____)_____

Address_____Relationship to Camper_____

Medications

Please fill out the Medications sheet including both prescription and non-prescription medications.

All medications in original prescription container and a list of those medications (and tobacco products) will be turned over to the staff at the time the Camper is registered. If the camper requires any additional treatments or devices that must be administered by a qualified staff person, this must be brought to the attention of the medical staff at the time of check-in. This includes, but not limited to, oxygen machines, assistive devices and/or sleep apnea machines. All medications (including non-prescription) will be dispensed by the designated member of the staff. **Also, to aid in the smooth transition of the Camper, we ask that all medications (up to and including the 8 pm dosage) be dispensed before leaving the Camper in the care of Adventure Camp staff.**

Please list additional medications on another page to give to the Adventure Camp Staff.

Does the camper use tobacco products? YES NO
(Smoking is prohibited in all buildings and only allowed in designated areas and designated times.)

1. Medication: _____
   Dosage/Frequency: _____

2. Medication: _____
   Dosage/Frequency: _____

3. Medication: _____
   Dosage/Frequency: _____

4. Medication: _____
   Dosage/Frequency: _____

5. Medication: _____
   Dosage/Frequency: _____

6. Medication: _____
   Dosage/Frequency: _____

7. Medication: _____
   Dosage/Frequency: _____

8. Medication: _____
   Dosage/Frequency: _____

9. Medication: _____
   Dosage/Frequency: _____

10. Medication: _____
    Dosage/Frequency: _____

*A current list of medications will be required when the camper arrives

Primary Care Physician Contact Information

In the event that the Camper goes to the emergency room, we would like to have their Primary Doctor's contact information.

Doctor's Name: _____

Doctor's Phone Number: (_____) _____

Doctor's Street Address: _____

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Parent/Guardian/Caregiver

It is most important that you provide essential information about the Camper's disabilities and specific needs. This is the information that we will use in arranging specific provisions for the Camper. **Registrations that do not provide information regarding disabilities will not be processed and notification will be made to the person responsible for filling out the form.**

Diagnosis and Disabilities (List All)

_____

_____

_____

Disability Involves (circle): Legs: R L, Arms: R L, Hands: R L, Head Breathing

Mobility: ___Independent with: ___Assistance ___Walker ___Crutches ___Wheelchair; ___Electric

For non-ambulatory campers, it is the responsibility of the parent/guardian/caregiver to provide a wheelchair (and/or necessary augmentative devices) that is safe and in optimum operational condition. Be certain that wheels, brakes and seatbelts are safe and fully operational.

Vision (circle): Normal Glasses Contacts Vision Impaired Legally Blind Hearing

(circle): Normal Hearing-Impaired Deaf Uses Hearing Aids (bring extra batteries)

Communication (circle): Verbal Sp. Difficulty Nonverbal Signs Gestures Seizure

Disorder: Type and Frequency:_____

Date of Last Seizure: _____ Wears Helmet: Y N

Special Care for Seizures:_____

_____

Allergies: _____

_____

Precautions/Special Instructions (to include any support needed with ADL's mobility, activities or redirection of behavior):_____

_____

Personal Care Information

Personal Care (circle one): Independent Requires Assistance Dependent

Level of care Required:

Bathing:_____

Toileting (circle one): Uses Urinal/Toilet Uses Bedpan Catheterizes Self Must Be Catheterized

Wears "Depends" Prompts after Toileting Assistance after Toileting

Mealtime (circle one): Uses Utensils Uses Fingers Special Container Requires Bib Uses Straw

Dietary Restrictions:_____

_____

Special Foods/Textures (to include assistance needed with meals: cut up, monitoring, feeding, etc:

_____

_____

Nighttime (circle): Night Incontinence Wears "Depends" Gets up during the night

Develops bedsores Sleeps on: Back Stomach Side (R L)

Other Considerations (frequency of getting up during the night, etc):

_____

Activities Camper should. NOT engage in: _____

_____

Discipline/Inappropriate Behavior Concerns (describe & include any restrictions or ways to redirect):

_____

Likes/Dislikes: _____

_____

Has the individual ever been the victim of abuse? Yes No

If yes, is there information we need to know related to the approach to care & support:_____

_____

Has this individual ever been known to harm themselves? Yes No

Explain:_____

Adventure Camp Retreat Agreement

I certify that the information provided on the application is true and accurate to the best of my knowledge. I assume full responsibility for all property belonging to _____. I will not hold Camp Calvary or any staff responsible for any damage to or loss of said property.

I request that Camp Calvary obtain the necessary emergency medical treatment for the above-named camper as needed. I understand that I and/ or my medical insurance provider will be responsible for all medical costs incurred for such emergency medical care required during the Retreat sessions indicated.

Photographs or video recordings made of the above-named camper, during the camp sessions indicated, may appear in promotional presentations made by Camp Calvary.

Please Note: Based on the level of care required for the Camper and the staffing patterns of each Adventure Camp session, you may be required to provide a caretaker for the duration of the session.

Please Note: We must be able to contact the Parent/Guardian or caregiver for the camper named on this application at any time, day or night, for the duration of the retreat. If you, as the signer (below) will, at any time, be unable to respond to any communication regarding the camper, you MUST provide an alternate contact person for the retreat coordinator to call. That person must be able to contact you promptly.

Refund Policy: In the event that the camper cannot attend the retreat that they signed up for, the option of rescheduling the camper to another retreat is possible. If rescheduling is not feasible and it is more than 14 days from the retreat time, a refund of $90 will be made. If the cancelation occurs within 14 days prior to the retreat, no refund will be made.

Signature Required:

_____ _____

Parent/Guardian/Caregiver Date

_____ _____

Camper Date

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In our efforts to meet the spiritual needs of campers, during the Adventure Camp sessions, we offer an opportunity for them to follow Christ's teachings to be immersed in baptism. Should this camper make this decision, we will follow your instructions as indicated below. If you have any questions about our belief regarding baptism by immersion, please call us. We welcome the opportunity to discuss this with you.

If _____chooses to be baptized:

_____I authorize Camp Calvary to perform the baptism.
_____I prefer to have my minister perform the baptism at our home church.
_____I request to be present at the baptism.
_____Has already been immersed.
_____May not be baptized.

Please mail the completed application and make checks payable to:

Camp Calvary

475 Camp Calvary Lane
Mackville, KY 40040

If you have any additional questions or concerns, please give us a call: 859-375-4376.