Camp Pathways
A Journey Through Grief

Friday, May 29th and Saturday, May 30th 2026

Again, this year we are including an opportunity to camp overnight and then participate in the Saturday encounter

Or…

Your child may elect to just come for the activities on Saturday

My child will come from Friday at 4:00pm to Saturday until 4:30pm _____

My child will attend Saturday Only activities 8:00am-4:30pm _____

Please Print:

Name of Child: _____

(Last) (First)

Home Address:_____

Street City/State Zip

Date of Birth_____ Age_____ Gender: _____

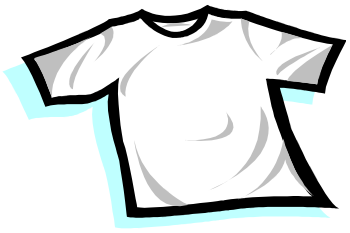
With whom is the child living?_____

Relationship:_____

Home or Cell Number: _____

Email: _____

A Camp Pathways Tee Shirt will be given to each attendee* (Must place order by 5/4/2026 to ensure size availability.)



Tee Shirt Size (please circle a size)

Youth: S M L Adult S M L XL

PERSONAL INFORMATION

Has this child attended any grief workshops before? Circle one: YES NO Year_____

Who is the significant person in this child's life who has died? _____

Relationship: _____

Cause of Death: _____ Date of Death: _____

Was this an extended illness? _____ How long? _____

How did you explain the death to your child? _____

Is the child currently receiving counseling? _____

Did your child attend the funeral service? _____ If not, why? _____

Is there any other information about the death you would like for us to know? _____

_____

_____

Has your child said or done anything recently that has concerned you? _____

If so, what? _____

_____

_____

Have there been any other major events for the family before or since the death? (Include divorce, moves, change of schools, new health problems, unemployment, financial hardship, etc.)

_____

_____

_____

Medication: Is the child taking medication? (Please list the medications, and their purpose):

_____

Confidentiality Statement

Northern Arizona Hospice/Camp Pathways staff and volunteers will uphold the confidentiality of camp participants. Participant information and communication regarding Camp Pathways will remain confidential, with the exception of:

- Mandatory reporting of any possible child/elder abuse
- The clear possibility of harm to yourself or others
- Court ordered release of records
- For case consultation or supervision
- For auditing purposes through the agency or funding sources

During camp, it is expected that personal information will be discussed. We ask camp participants to honor the confidentiality of other campers. **Your signature indicates that you have explained the importance of confidentiality to your child(ren) and will assist them in maintaining confidentiality.**

_____

Signature of Parent/Legal Guardian **Date**

In what ways are you hoping to benefit from Camp Pathways? (please check all that apply)

- ❑ To give our child a safe place to grieve
- ❑ To meet others who have experienced a similar loss
- ❑ To help my child cope with the death
- ❑ To help my child better understand death
- ❑ To help my child to express feelings about the death
- ❑ Other: _____

How did you hear about Camp Pathways? _____

Comments you would like to share about your child that was not included on the application:

_____

This application has been completed by: _____

Relationship to child: _____

Camp Pathways Agreement

I,_____, give permission for my child,_____,
to attend Camp Pathways. The information included in this application is completed honestly and correctly to the best of my knowledge. I give permission for the child to participate in camp activities, except as noted:

If the child(ren) appear(s) to be ill, I will not send him/her to the camp.

I give permission for general first aid/medical treatment to be administered to the child as deemed necessary in case of illness and/or injury. I agree to hold Northern Arizona Hospice/Camp Pathways, including staff/volunteers harmless from any and all claims of injury sustained by the camp participant(s).

I agree to hold Northern Arizona Hospice/Camp Pathways staff/volunteers harmless to any claims of any and all personal injury, whether physical or emotional, and injury/damage to property sustained by camp participant(s).

If at any time throughout the camp, the participant(s) become disruptive, I understand that they could be asked to leave. As the responsible party, I agree to remain available if I need to be contacted by phone concerning my child(ren) for any reason, and to remain available to pick the child(ren) up to take them from camp if deemed necessary.

I give permission to Camp Pathways to share the information provided on this application with counselors or volunteers who will be working with these children/adults.

Signature of Parent/Legal Guardian_____Date_____

Pick up and Drop off Schedule

If camping overnight, Drop off: Friday May 29th 2026 at 4:00pm and Pick Up at 4:30pm on Saturday May 30th

If only attending the Saturday activities, please drop off your child on Saturday, May 30th at 8:00am and pick up Saturday at 4:30pm.

Location of Camp:

Adventure Encounter

1875 Mabery Ranch Road

Cottonwood, AZ 86326

The campgrounds are located on the same grounds as Blazin' M Ranch. Off 89A. Turn onto 10th Street and follow signs to Blazin M Ranch.

You may email, mail, drop off, or fax this application to:

Northern Arizona Hospice
Camp Pathways
Attention: Ed Gardner
Email: edward.gardner@lhcgroup.com
Cottonwood: 203 South Candy Lane, Suite 2A
Cottonwood, 86326
Fax: 928-639-6078

If you have any questions or need assistance in completing the application please contact Ed Gardner @ 928-639-6676 (O) or 559-759-2966 (M)

APPLICATIONS ARE OPEN

Applications Due May 4th, 2026

COMMUNICATIONS DEPARTMENT
901 Hugh Wallis Rd S | Lafayette, LA 70508
P: 337.233.1307 | LHCGroup.com

HIPAA AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES

I, the undersigned, authorize LHC Group, Inc. and its subsidiaries and affiliates ("LHC Group") to use the following information as part of its marketing, communications, or fundraising activities:

- My name
- My photographic image and/or recorded video
- My age
- My city and state of residence
- My testimonial, story, and/or quotes, including information regarding my care and treatment

I also authorize LHC Group to disclose this information to the general public for marketing and fundraising purposes through social media, websites, brochures, and other related media sources. Recipients of this information may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of this information.

I understand that I have the right to revoke this Authorization by providing a written notice to **[LHC Group Communications Dept. at ask.communications@lhcgroup.com or mail to 901 Hugh Wallis Rd S, Lafayette, LA 70506 Attn. Communications]**. I understand that such revocation will be effective upon LHC Group's receipt of my written notice, except that the revocation will not have any effect on action previously taken by LHC Group in reliance on this Authorization. By signing this form, I understand that LHC Group's reliance on this Authorization begins upon execution.

I understand that this Authorization is voluntary and LHC Group may not condition treatment, payment, or eligibility for benefits on my signing this Authorization.

This Authorization shall expire three (3) years from the date of my signature unless I revoke this Authorization sooner.

I have read and understand the terms of this Authorization, and I agree to those terms. I understand that I have a right to receive a copy of this Authorization upon my request and that a copy of this Authorization shall be as valid as the original.

Date: _____

_____ _____
Name of Patient/Employee (Please Print) Signature of Patient/Employee's Legal Representative

_____ _____
Printed Name of Legal Representative Authority to Act for Patient/Employee

COMMUNICATIONS DEPARTMENT
901 Hugh Wallis Rd S | Lafayette, LA 70508
P: 337.233.1307 | LHCGroup.com

PHOTO CONSENT

I, the undersigned, authorize LHC Group, Inc. and its subsidiaries and affiliates ("LHC") to use and disclose my name and/or one or more photographs, video recordings or audio recordings for purposes deemed appropriate by LHC, which may include, but not be limited to, marketing, promotional, public relations, recruiting, training, social media, advertising, and other internal or external purposes.

I acknowledge that the photographs and recordings will be the sole property of LHC. I understand that consenting to the use of my photographs and recordings is of no direct benefit to me. I waive any and all rights that I may have to any claims for payment or royalties in connection with the use and disclosure of such information. I will hold LHC harmless from and against any claim for injury or compensation resulting from the use of my photographs and recordings in accordance with this consent.

I acknowledge that I can ask LHC to stop using my photographs and recordings at any time; however, LHC will not be able to recall any previous use or disclosure of my photographs and recordings.

Date: _____

_____ _____
Name of Patient/Employee (Please Print) Signature of Patient/Employee's Legal Representative

_____ _____
Printed Name of Legal Representative Authority to Act for Patient/Employee