

♥Camp Healing Hearts♥

...a very special project
of Hospice of Central New York

Camper's Application

Child's Name: _____
Child's Nickname: _____
School grade recently completed: _____ Age: _____
Birth Date: ____/____/____ Sex: M F
Race: (optional): _____
Please list your child's religious affiliation, if any (optional): _____
Current School: _____

Parent/Guardian's Full Name: _____
Street Address: _____
City: _____
Home Phone: () _____ Work Phone: () _____
E-mail Address: _____ Cell Phone: () _____

Emergency Contact: _____
Relationship: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Name of Child's Physician: _____ Phone: () _____
Name of Child's Dentist: _____ Phone: () _____
Hospital of Choice: _____

Child's Health Care Carrier: _____ Effective Date: _____
Plan Number: _____ Group Number: _____

Child's T-Shirt Size:

Children _____ S (6-8) _____ M (10-12) _____ L (14-16)
Adult _____ S _____ M _____ L _____ XL

How did you hear about Camp Healing Hearts (referral source)? _____

Bereavement History

Please include as many details as possible when answering the following questions.

Attach extra pages if necessary.

1. Who was/were the person(s) who died (name)? _____
2. How was/were the person(s) related to the child? _____
3. What was the cause of death? _____
4. When did the death occur (date)? _____
5. Age of your child when the death occurred? _____
6. Was the person(s) who died a Hospice of Central New York patient? Yes No
A patient in another hospice program? Yes No
7. Did the child attend the funeral/memorial services? Yes No If "yes", what was your child's reaction to/or about the service? _____
8. Has your child received any professional support (i.e. school counselor, peer support group, psychologist, psychiatrist, pastoral counselor)? Yes No (if "no", skip to #10)
9. Please explain how your child indicates that he/she is still grieving. _____

10. Have there been multiple deaths of loved ones experienced by this child? Yes No
If "yes", please describe the nature of death and the child's relationship to the other person who died. _____
11. Have there been any other changes/stresses in your child's life (i.e. divorce, remarriage, relocation, illness)? _____
12. If you feel there is any relevant information that has not properly been communicated through this application about your child, please use the space provided below to add whatever information you feel we should be aware of. _____

Release:

In consideration of the above named child being granted permission to attend Camp Healing Hearts: I agree to indemnify and hold harmless Hospice of Central New York and Camp Healing Hearts for any and all claims, demands, actions and judgments whatsoever of every name and nature, both in law and equity, which my child ever had or now has or may have had against Camp Healing Hearts for all personal injuries, either physical or emotional, known or unknown, and injury to property, real or personal, sustained by my child's person or property during his or her attendance at Camp Healing Hearts, including but not limited to, injury caused by or arising from Camp Healing Hearts' own negligence.

I, the undersigned, have read this release and understand all of its items.

Signature of Parent/Guardian Date: _____

Signature of Parent/Guardian Date: _____

Health History

Child's Height: _____ Child's Weight: _____

Parent/Guardian's Phone: Day _____ Evening _____

Health History (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Attention Deficit Disorder (ADD) | <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) | |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Allergies (foods, animals, bee stings) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fears | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Special Dietary Needs | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Wears Glasses | <input type="checkbox"/> Wears Contact Lenses | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Developmentally Delayed | <input type="checkbox"/> Other (please explain) | (please explain) |
-
-
-

Recent Surgery (type & date): _____

Serious Injury (type & date): _____

Chronic or Recurring Illness: _____

Please explain any information we need to know to care safely for your child: _____

May we dispense *Tylenol* in the dosage appropriate for your child's weight, if needed? Yes No

Last tetanus shot: _____

Medications: _____

Are there any activities your child may not be able to participate in while at camp? Yes No

If "yes", please explain: _____

Food Allergies: _____ Drug Allergies: _____

Other Significant Allergies: _____

Please list any other dietary restrictions (physician recommended/religious, etc.) _____

Physician's Name: _____ Phone: _____

To the best of my knowledge, the above information is correct and accurate.

Date: _____

Signature of Parent/Guardian

I give permission to agents of Camp Healing Hearts to administer first aid to my child and authorize emergency transport to the nearest acute care facility.

Date: _____

Signature of Parent/Guardian

Parental Authorization

I/We authorize and request Camp Healing Hearts to administer the medication(s) prescribed by our physician, and in so doing relieve the camp, its agents, employees or representatives, of any responsibility for ill effects which may result from the administering of said prescribed medication as per the physician’s directions listed above.

_____ Date: _____
Signature of Parent/Guardian

Indemnification Agreement

1. I, _____, hereby give permission for my child to attend Camp Healing Hearts on August 23-26, 2010.
I understand that the camp’s goal is to help facilitate the bereavement process of my child and provide support for him/her in expressing feelings of grief.
2. I give permission for my child to be photographed, videotaped or interviewed during Camp Healing Hearts under staff supervision. This material may be used for future publicity of Camp Healing Hearts, including the news media. __Yes __No

Please return completed form to:
Hospice of Central New York
Attention: Heather Hay
990 Seventh North Street
Liverpool, NY 13088

If possible, please include the registration fee of \$25.00 per child or \$50.00 per family. If this is not possible, there are scholarship funds available to cover the registration fee, and simply return the application forms.