20th Annual Kids' Grief Camp

Camp HOCO Registration

Hospice of Central Ohio

Child's Name: _____ Prefers to be called: _____

Date of Birth_____ Age _____ School_____ Grade_____

Child's address_____

Street *City* *Zip*

Parent Email address_____

Parent/Legal Guardian Phone: Day_____Evening _____Cell_____

Please list everyone who lives in the household:

Name (first and last)	Age	Relationship to child	Quality of relationship Excellent, Good, Fair, Strained, Difficult

Name of person who died_____ Relationship to child_____

Date of death_____ Cause of death _____The person's age at time of death_____

Was the child living with this person at the time of death? _____ Was this death anticipated? _____

How did child learn of the death?

Please indicate any other deaths your child has experienced:

☐ Parent ☐ Sibling ☐ Friend ☐ Teacher

☐ Grandparent(s) ☐ Aunt/Uncle ☐ Neighbor ☐ Pets

Please list names, dates, and details of these deaths:

_____

_____

_____

What most concerns/worries you about your child's experience of grief? _____

_____

What are your hopes & expectations for your child's camp experience?_____

_____

Please check the following box if your child may not be photographed for any reason. ☐

Please select your child's shirt size:

Children - S

T-shirt size (select one) *many children wear adult size shirts*

Child Size: S M L

Adult Size: S M L XL

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I, _____, as parent or legal guardian of child, _____
first name last name child's first name child's last name

hereby give my permission for said child to participate in programs and activities of Children's Bereavement Services of Hospice of Central Ohio. I understand that the goal of Children's Bereavement Services is to facilitate the grieving process of my child and provide support for her/him in expressing feelings associated with grief. This will be done through artistic activities, music and small group settings.

Please list any dietary restrictions or food allergies, or write "None"

Please list any physical restrictions, limitations or environmental allergies your child may have, or write "None"

Please list any cognitive or emotional limitations your child may have, or write "None"

Questionnaire

Please complete this questionnaire by checking the appropriate box. Please mark your honest, first reaction to each question.

	1. Never	2. Seldom	3. Sometimes	4. Often	5. Frequently	N/A
1. My child has good control of her/his behavior	○	○	○	○	○	◉
2. My child's mood changes quickly	○	○	○	○	○	◉
3. My child is able to talk about his/her emotions	○	○	○	○	○	◉
4. My child can accurately describe feelings	○	○	○	○	○	◉
5. My child displays confidence	○	○	○	○	○	◉
6. My child copes well with change	○	○	○	○	○	◉
7. My child shares memories about the deceased	○	○	○	○	○	◉
8. Our family talks about the deceased	○	○	○	○	○	◉

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Authorization to Consent to Medical Treatment of a Minor

The undersigned consents on behalf of the below-named minor, who is less than eighteen (18) years of age, in the event all reasonable attempts to contact me at the telephone numbers set forth below have been unsuccessful for:

1. The administration of any treatment deemed necessary by Dr. _____ (preferred physician) Phone number _____ or by Dr. _____(preferred dentist) Phone number _____ or in the event the appropriate specified practitioner is not available, by another licensed physician or dentist;
2. The transfer of minor to _____ (preferred hospital) or any hospital reasonably accessible.
3. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained in writing prior to the performance of such surgery.
4. The following information sets forth the minor's medical history including allergies, medications being taken and any physical impairment to which the physician or dentist should be alerted. Please include food allergies.
   a. Allergies: _____
   b. Medications being taken: _____
      Check if child will need medication administered during camp.
   c. Date of last tetanus shot: _____
   d. Physical impairments: _____
   e. Other pertinent facts: _____

Name of minor: _____ Date of birth: _____ Age: _____

Address: _____ Phone number: _____

Parent/Legal Guardian 1) _____2) _____

Address: _____

Phone number: 1) _____2) _____

Emergency Contact Person (This person will be called in the event of an emergency if parent/guardian cannot be reached by phone):

Name: _____ Phone: _____Relationship: _____

Health Insurance Company: _____

Identification Number: _____ Group Number: _____

X _____ _____

Parent/ Legal Guardian Signature Date

INDEMNIFICATION AGREEMENT

Also in consideration of the above-named child being granted permission by Hospice of Central Ohio to participate in children's bereavement activities:
I AGREE TO INDEMNIFY AND HOLD HARMLESS HOSPICE OF CENTRAL OHIO FOR ANY AND ALL CLAIMS, DEMAND, 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 AGAINST HOSPICE OF CENTRAL OHIO 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/HER ATTENDANCE AT SUCH ACTIVITIES, INCLUDING BUT NOT LIMITED TO, INJURY CAUSED BY OR ARISING FROM HOSPICE OF CENTRAL OHIO'S OWN NEGLIGENCE.
I, the undersigned, have read this release and understand all its terms.

X _____ _____

Signature of parent/legal guardian Date

SUBMIT FORM