Camp HOCO Registration

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:

T-shirt size (select one) *many children wear adult size shirts*
Child Size: S M L
Adult Size: S M L XL

CAMP HOCO

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Hospice of Central Ohio

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