Point of Hope Middle School Grief Day Camp

Sunday, November 5, 2017 Glasgow Farm 10:00 a.m. - 5:00 p.m.

REGISTRATION FORM AGES 12-15 6th-9th Grade Students

In order to attend Point of Hope Camp, your child must be pre-registered. Registrations will be made on a first-come, first-serve basis and may include an interview. Registration priority will be granted to children who are recently bereaved and have not yet attended POH Camp.

PLEASE COMPLETE A REGISTRATION FORM FOR EACH CHILD* and return via mail, fax or scan and email by October 27th *to: Point of Hope Camp, Capital Caring, Tara Hoit

111 Olde Greenwich Dr. Ste. 101 Fredericksburg, VA 22408

thoit@capitalcaring.org fax: 540-940-2767 phone: 540-295-7223

Once your child has been accepted, you will receive further detailed information.

Child's First Name:_____ Child's Last Name: _____

Parent/Guardian Name: _____

Address: _____

City:_____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

E-mail address (parent): _____

Age: ____ Date of Birth: ___/___/___ Race:___ Gender: ☐ Female ☐ Male

T-shirt size:
Child: S____ M_____L____ XL____ *Adult:* S____ M____ L____XL____ XXL____

School child is attending:
_____

How did you learn about Point of Hope Camp?
_____

Please provide the following information about the person who died.

Was your loved one a Capital Caring patient? ☐ Yes ☐ No

Name of loved one: _____Relationship to child**:** _____

Date of Death: ___/___/___ Age at Death: ____ Cause of Death: _____

Briefly describe the circumstance leading up to the death including the nature of the death and the length of illness, if any:

_____

_____

How did your child react to the illness?_____

_____

How did your child react to the death?_____

_____

What have been your observations of your child since the death?_____

_____

_____

Did your child attend the funeral or memorial service and how did he/she cope with that experience?

_____

_____

Describe the relationship between your child and the person who died (i.e. close, distant, strained, loving, etc):

_____

_____

Please list any other significant losses in your child's life and approximately when they occurred (i.e. family members, pets, friends, divorce, a move):

_____

_____

Describe your child's support network of family, friends, school, and community:

_____

_____

Does your child have any attention, behavior, or learning difficulties? Please specify.

_____

_____

Does your child have a history of depression or anxiety?

_____

_____

Please describe any difficulties your child has with the following:

- School attendance or getting along with friends/family members

_____

_____

Is there any other information that would be useful for us to know to provide the best possible camp experience for your child?

_____

_____

Child Medical History Form

PLEASE COMPLETE A SEPARATE FORM FOR EACH CHILD.

Each child must have a Medical Emergency Form on file in order to participate in Capital Caring Day Camp.

Name of Child _____ Birth date _____ Gender _____ Age _____

Parent/Guardian _____

Home Address_____

Home Phone _____ _____Alternate Phone _____

Emergency Contact (other than parent) _____

Home Address_____

Home Phone _____Alternate Phone _____

Name & ID # of Health Plan _____

HEALTH HISTORY (check if your child has ever had any of the following medical complications)

_____ Frequent ear infections

_____ Diabetes

_____ Epilepsy

_____ Mononucleosis

ALLERGIES:

_____ Hay Fever

_____ Poison Ivy

_____ Insect Stings

_____ Food _____

_____ Asthma

_____ Penicillin

_____ Other Drug

Will your child be bringing any medication? _____ No _____ Yes

If yes, please complete box below: ***All medications must be contained in the original prescription bottle and must have your child's name and prescribed dosage listed***.

Name of Medication	Dosage	Times Taken

ALL MEDICATIONS BROUGHT TO CAMP MUST BE TURNED IN. A REGISTERED NURSE OR PHYSICIAN WILL ADMINISTER ALL MEDICATIONS.

Please check over-the-counter medications that may be administered as deemed necessary by camp medical personnel:

↑Tylenol ↑Ibuprofen ↑Benadryl ↑Dramamine
↑Antacid ↑Hydrocortisone ↑Artificial tears ↑First Aid Cream

Activities that should be restricted or physical limitations: _____

_____

Date of last Tetanus Vaccination: _____

Only medications listed on this form will be brought to camp and must be turned in to the Camp Nurse upon arrival. I authorize the Point of Hope Camp Nurse to administer first aid and dispense medications including over-the-counter medications as necessary.

_____ _____

Parent/Guardian Signature Date

AUTHORIZATION AND CONSENT TO TREAT A MINOR

I hereby give permission and authorize Capital Caring staff/designees to provide to: (Camper's name)_____ routine health care, first aid, administer prescribed medications, and seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to Capital Caring Camp staff to arrange necessary related transportation for the camper. In the event I cannot be reached in an emergency, I hereby give permission to the physician, dentist, or other health care provider selected by Capital Caring Camp staff to secure and administer treatment, including hospitalization, for the camper and acknowledge that I will be responsible for the payment of all charges related to the health care services.

This form may be photocopied for use outside of the camp to secure treatment.

_____ Date: _____
Parent/Guardian Signature

Release of Liability

I understand and agree that Capital Caring, its Board of Trustees, Officers, Employees, and Volunteers are released from any legal responsibility and/or liability for negligence arising out of any accidents or illnesses, which occur while the child listed below attends Point of Hope Camp.

Child's Full Name: _____

Child's Birth Date: _____

Parent/Guardian Signature: _____ Date: _____

This signed release is required for camp attendance.

Media Statement

Each year at Capital Caring, we document various camp activities to record these amazing experiences. We use photos, voice and video recordings from camp to train staff, recruit volunteers, raise community awareness and secure the donor support that allows us to offer the camp at no charge to participants. We have found that these images and words from campers are uplifting and inspiring, so we often include them in the annual update to our camp brochure and in our community newsletter which is mailed directly to our donors. For the same reasons, we also try to interest the media in doing stories about the camp.

We can assure you that when media visit our camp, they are educated about the need for sensitivity and staff always escorts them. While we know in advance how we plan to use our images and recordings from camp, we are unlikely to know in advance if or which media might choose to do a story on camp. Thus, we have used the term “accredited newspaper, radio and/or television media” on the enclosed Media Release and Consent to cover the typical last-minute media decision to visit the camp. We are asking you to please sign the enclosed consent form and return it to us.

If you have any questions, please don’t hesitate to call us directly at 703-712-4869 ext. 4 and we will be happy to address your concerns.

Sincerely,

Tara Hoit
thoit@capitalcaring.org 540-295-7223

Kristi Difilippo
kdifilippo@capitalcaring.org 540-735-0972

Media Consent & Release Form

Capital Caring depends on the generous support of the community to provide for programs such as Capital Caring Day Camp. In order to inform the community of this activity, it is helpful to have photographs and interviews with participants. Photographs, audio and video recordings, and quotes from participants at Capital Caring Day Camp are frequently useful in demonstrating the hospice philosophy and the care that is given.

I hereby give permission for Capital Caring to photograph and/or interview me (or my minor child named below), and to use these images, recordings and quotes for training, promotional and educational purposes, and for any accredited newspaper, radio and/or television media, at the discretion of Capital Caring, to photograph and/or interview me (or my minor child named below) for news and feature reporting. I give Capital Caring permission to discuss the grief and loss support provided and the circumstances surrounding my grief and loss care needs. I understand that by signing this consent, I am authorizing release of protected health information.

_____

Name of participant (please print)

_____ _____

Signature or signature of parent/guardian (if under the age of 18) Date

_____

Relationship of signer to participant

Address and phone number of signer:

_____

_____

_____