CAMP I BELIEVE

CAMPER NAME

CAMP I BELIEVE: CAMPER APPLICATION
Fortson 4H Center
Hampton, GA
Saturday, September 16th-Sunday, September 17th, 2017

CAMPER INFORMATION

Last First Middle "Nickname"

Street Apt# City State Zip

DOB Age Grade Next Fall Gender

T-Shirt Size: *Adult Size* ☐ Small ☐ Medium ☐ Large ☐ X-Large

Child Size ☐ Small ☐ Medium ☐ Large

GUARDIAN INFORMATION

Last First Relationship to Camper

Address (If different than above)

Home Phone Cell Phone Email

CAMPER NAME

EMERGENCY CONTACT INFORMATION (other than guardian previously listed)

Last First Relationship to Camper Phone Number(s)

How did you hear about Camp I Believe? (please identify specific referral source)

Has your child ever attended a **prior** camp (Camp I Believe, Camp Odyssey, Camp Healing Hearts, etc.)?

Has your child ever spent the night away from home prior to camp? Yes No

Does your child ever have issues sleeping (i.e. bedwetting, nightmares)?

MEDICAL INFORMATION

Does this camper have any medical/ mental health condition(s) of which we need to be aware?

☐ YES ☐ NO

If yes, please explain in detail.

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Is this camper currently under the care of a physician/ psychiatrist/ therapist? ☐ YES ☐ NO

If so, please provide the name and contact information below:

_____

_____

_____

Does your child have any allergies? ☐ YES ☐ NO

If yes, please describe below:

_____

_____

_____

In the event of an emergency, do you have a HOSPITAL OF CHOICE? _____

Does your child have any of the following? *Please check all that apply*

☐ Asthma	☐ Seizures/ Convulsions	☐ Headaches/ Migraines
☐ Diabetes	☐ Hearing Impairments	☐ Physical Limitations
☐ Bleeding Disorder	☐ Nosebleeds	☐ Wear glasses/ contacts
☐ ADD/ADHDD	☐ Motion Sickness	☐ Other_____

MEDICATIONS

I give permission for the administering of the following over the counter medications, as deemed necessary, by the camp nurse(s). Dosages will be administered according to the directions on the bottles unless a physician directs otherwise. Check all that apply:

AILMENT	MEDICATION	INITIAL (if permission granted)
Headache	Tylenol	
Upset Stomach	Pepto-Bismol	
Diarrhea	Imodium AD	
Menstrual Cramps	Ibuprofen	
Poison Ivy	Calamine Lotion	

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Is the camper currently taking any medications? YES ☐ NO ☐ If yes, please list below:

NAME OF MEDICATION	DOSAGE/ FREQUENCY	ADDITIONAL INFORMATION

ALL MEDICATION is to be presented in the original prescription bottle from the pharmacy. Vitamins must also be in original containers. ALL MEDICATIONS must be in a zip lock bag with the camper's name written on it and given to the CAMP NURSE(S) at drop off/ registration. Unlabeled or mislabeled medications cannot be given at camp. You must provide the appropriate mediations for the entire duration of the camp. PLEASE NOTE: We do not accept pre-filled medication containers

By signing this, I agree to allow Kindred Healthcare, Inc. (Camp I Believe) to administer the above prescribed medications and any necessary over the counter medications to this camper. I also give permission for the staff to transport the camper to and from the campsite should there be a medical emergency. I also give my permission to the doctors and the hospital(s) to treat my child as medically necessary, in the event of a medical emergency.

Signature of Guardian Printed Name

Physician's Name Physician's Phone Number

CAMPER NAME

BEREAVEMENT HISTORY

It is important that you include as many details as possible when answering the following questions. We understand that answering some of these questions might be difficult; however, we want to be able to provide the best possible care for your child. Attach extra pages as necessary.

1. Full name of the person who died (Deceased): _____
2. Relationship of the Deceased to the Camper:_____
3. Cause of Death: _____
4. Date the death occurred/ Age of Deceased *at time* of Death: _____
5. Camper's age when death happened: _____
6. Did the Deceased live with the Camper? ☐ YES ☐ NO
7. Describe the relationship between the Camper and the person who died:

   _____

   _____

   _____

   _____
8. Where did the person die? ☐Home ☐Hospital ☐ Other Location: _____
9. Was the Camper present when the death occurred? ☐ YES ☐ NO
10. Was the Camper told <u>the facts</u> regarding the cause of the loved one's death? ☐ YES ☐ NO
11. What was the Camper's reaction to the death (sad, angry, anxious, etc.)?

    _____

    _____

    _____

    _____

    _____

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12. Did the Camper attend the memorial/ funeral service? ☐ YES ☐ NO

If YES, what was the Camper's reaction?

_____
_____
_____

13. How would you describe your family's communication style regarding the death?

☐ Open ☐ Adequate ☐ Closed ☐ Avoidance ☐ Other:_____

14. Please explain how the Camper indicates that he/ she is grieving (having a difficult time):

_____
_____
_____
_____

15. Has your child received any professional support (i.e. met with a school counselor, mental health therapist, peer support group, psychiatrist, pastoral support, etc.)?

_____
_____

16. Have there been any other changes/ stressors in the Camper's life (i.e. illness, relocation, changes in school, divorce/ remarriages, etc.)?

_____
_____
_____
_____

17. Are there any language, disability, and/ or religious needs that we should be aware of to best serve the Camper?

_____
_____
_____

18. Is there anything else that you think we should know to best support the Camper?

_____
_____
_____

_____

Signature Relationship to Camper Date

_____

CAMPER NAME

CAMPER QUESTIONNAIRE

(To be completed by the camper)

1. What name do you like to be called? _____

2. What is your favorite activity? _____

3. What is your favorite book? _____

4. What is your favorite kind of music? _____

5. Is there anything you would like to tell us to help us take better care of you?

_____

_____

_____

6. Who was the special person in your life who died?

_____

_____

7. How long ago did they die? How old were you? _____

8. What do you miss the most about your loved one?

_____

_____

_____

_____

_____

_____

Camper Signature

CAMPER NAME

CONSENTS

- I give permission for the Camper to attend Camp I Believe. It is my understanding that it is the goal of the camp to help facilitate the bereavement process for the Camper and to provide support in expressing feelings of grief.

- I give my permission for the Camper to be photographed during Camp I Believe. I understand that the photographs will remain property of Kindred Gentiva Hospice Foundation and Kindred Healthcare, Inc. and may be used for publicity of Camp I Believe, including, but not limited to future camp brochures, newsletters, social media and presentations released by Kindred Gentiva Hospice Foundation and Kindred Healthcare, Inc.

- I understand that the Camper will be supervised by trained staff and volunteers throughout the duration of camp. However, I recognize that children at camp can injure themselves without fault on part of Camp I Believe staff, volunteers, or partners. I release Kindred Healthcare, Inc. (Camp I Believe) from responsibility for injury to the Camper.

- If I cannot be contacted in the event of an emergency, I hereby give consent for the staff/ volunteers of Camp I Believe to access treatment and for the emergency room physician/ consulting physician to treat the Camper. Kindred Healthcare, Inc. (Camp I Believe) has permission to obtain a copy of the above Camper's health record from the providers treating him/ her.

- I understand that the information I have provided about the Camper will be shared on a "need to know basis" with Camp I Believe staff and volunteers and that information will be kept in the strictest confidence.

CAMPER NAME

- I understand that if the Camper becomes disruptive at any time during the duration of camp that the Camper may be asked to leave and the guardian will be expected to transport the camper from the camp site.

- I expressly assume any and all risks of injury or death arising from or relating to the Camper's activities at Camp I Believe and waive and release any and all actions, claims, suits or demands of any kind or nature whatsoever against Kindred Healthcare, Inc., its corporate affiliates, contractors, vendors, officer, agents, sponsors, volunteers or representatives of any kind (collectively "Releasees") arising from or relating in any way to Camper's voluntary participation in these activities. I understand that this Waiver, Release and Indemnification agreement means, among other things, that if Camper is injured or die as a result of participation in these activities, I, and/or my family or heirs cannot under any circumstances sue Releasees or any of them for damages relating to or caused by my injuries or death.

- I agree to indemnify Releasees or any of them, and their subrogees, if any, in the event of any loss, damage or claim arising from or relating in any way to Camper's participation in any Camp I Believe activities.

I have read, understand, and acknowledge the above statements, and wish for the Camper to participate in Camp I Believe.

Signature of Guardian Printed Name Relationship to Camper Date

Return this Application to:

Camp I Believe
Attn: Caroline Bufalini
2302 Parklake Drive
Suite 150
Atlanta, GA 30345
(P): 678-937-1088
(F): 678-937-1901

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