For office use only
Application Received _____
Acceptance Packet Sent: _____

SKY Camp Application 2017

Kindred Gentiva Hospice Foundation
June 23 – 25, 2017

Application completed by Parent/Guardian
Please Print Clearly ***Due May 31, 2017 Date: _____

SKY Camp is for first time campers. Is your child a previous camper? _____

If yes, when? _____

Child's Name: (Last)_____ (First)_____ ☐ Male ☐ Female

Address: _____ City: _____ St: _____ Zip: _____

Birth Date: _____ Age at Camp: _____ School:_____ Grade: _____

Parent /Guardian: (Last) _____ (First)_____

Relationship to Child: _____

Address (if different from child): _____City: _____ St: _____ Zip: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell: (____)_____

E-Mail Address Parent/Guardian: _____

Emergency Contacts (other than guardian previously listed) who is available day and night:

_____
Name Relationship to Camper Phone Number(s)

_____
Name Relationship to Camper Phone Number(s)

Religious Preference/Church Membership: _____

Referred by: _____ Phone: (_____)_____
Title

Please list all children in your family with their date of birth:

Child Name	Date of Birth	Age	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who lives in your home? List all: _____

_____

Please complete the following questions to help acquaint our staff with your child's experience with death:

1. Please give the name of the person who died. _____

2. What was the child's relationship to the deceased? _____

3. When did the death occur? _____ What was the cause of death? _____

4. Have you noticed any changes in your child's behavior since the death of your loved one? Explain:

   _____

5. Describe how your child shows his/her grief (give examples of behavior). _____

   _____

6. Have these created any problems at home or school? _____

   _____

7. Describe how your child responds to authority. Are there any discipline concerns we should be aware of?

   _____

   _____

8. Have there been any other significant changes in the child's life (moving to a new home or school, divorce, remarriage or other deaths)? _____

   _____

9. Has your child shown any physical symptoms of grief? Please explain: _____

   _____

   _____

10. Has your child received any professional support (i.e. school counselor, mental health counselor, peer support group, psychiatrist, pastoral support)?

    _____

    _____

    Has there been a psychological evaluation? ☐ Yes ☐ No What diagnosis? _____

    _____

11. Has the child ever been assessed for attention or learning disabilities? If yes, please explain in detail.

    _____

    _____

12. Is your child taking any medications? If yes, please list: _____

    _____

    _____

13. Has your child ever spent the night away from home? How was that experience for him/her? _____

_____

14. How do you think your child will cope with sleeping in a camp environment? Explain. _____

_____

15. Does your child have nightmares, sleepwalk, wet the bed or have any other nighttime difficulties? Describe in detail.

_____

_____

16. What do you desire your child to gain from SKY Camp? _____

_____

17. Is there anything else you would like us to know about your child? _____

_____

One of our SKY Camp traditions is to honor our loved ones by wearing a bead(s) on our nametag to represent their love in our life. Please indicate below the loss(es).

BEREAVEMENT HISTORY

Relationship	Date of Death	Age at Death	Cause of Death	Hospice	If Yes, which Hospice
				Yes No	
				Yes No	
				Yes No	
				Yes No	

Please check one for the Camp T-shirt:

(Adult sizes) ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ XX-Large

(Child size) ☐ Small 8-10 ☐ Medium 10-12 ☐ Large 12-14

SKY CAMP RULES

DISCIPLINE POLICY
Children who present a discipline problem may need to be picked up early from SKY Camp by the parent/guardian or designated responsible adult.

SAFETY RULES/EMERGENCY NOTIFICATION
Safety is our utmost priority. The following will not be tolerated and may result in parent/guardian notification and removal of the child from SKY Camp:

- Leaving assigned areas without staff approval.
- Endangering self or others.
- Sexual activity.
- Drug, alcohol or tobacco possession and/or use.

I give my permission for _____ to participate in SKY Camp.

Parent/Guardian Signature: _____ Date: _____

MEDICAL CONSENT

I, the parent/guardian of _____ give permission for said child to receive First Aid Treatment, which may involve the administering of over the counter medications. I also give permission for the SKY Camp medical staff to assess and treat all medical situations and to secure emergency medical services for my child, if necessary.

Parent/Guardian Signature: _____ Date: _____

RELEASE OF LIABILITY

In consideration for attending SKY Camp, I understand and agree that Kindred Hospice, the Kindred Gentiva Hospice Foundation, its Board of Directors, 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 attending SKY Camp.

Parent/Guardian Signature: _____ Date: _____

PUBLICITY/CONFIDENTIALITY RELEASE

I hereby consent that Kindred Hospice, the Kindred Gentiva Hospice Foundation or programs approved by the Kindred Gentiva Hospice Foundation be authorized to use my name, title, portrait, picture, video image, photograph, or any reproduction likeness of me or quotation of my remarks, for public information, fund-raising purposes and use of the other hospice programs as approved by Kindred Gentiva Hospice Foundation.

Permission is hereby granted to use personal information about myself, my family and the circumstances of my relationship with Kindred Gentiva Hospice Foundation as deemed appropriate by Kindred Gentiva Hospice Foundation or the above named entities for the same purposes.

I agree to be confidential and I promise not to tell anyone what others say or what others do at SKY Camp. I can only share what I say or what I do, not what anyone else says or does.

I understand that my group leaders and all other volunteers will keep my confidences at all times, except if it is believed I am going to harm myself or someone else, or someone is harming me. I understand that the leaders are required by law to report any suspected child or elder abuse, or serious threats of harm to myself or another person, to the proper authorities.

Parent/Guardian Signature: _____ Date: _____

Child Signature: _____ Date _____

WE CERTIFY THAT THE INFORMATION GIVEN IS COMPLETE AND TRUE

Parent/Guardian Signature: _____ Date: _____

Return completed application by May 31, 2017 to:

Kindred Hospice
ATTN: Allison Rankin
3232 Hobbs Rd.
Amarillo TX 79109

(806) 372-7696 or Fax: (806) 372-2825

Registration will be processed only when all pages are fully completed and returned. *(Child completes page 5)

Additional Comments

_____

_____

_____

_____

SKY CAMP 2017

****To Be Completed by Camper****

Please Print

Name: _____ Age:_____

What is your favorite book? _____

What is your favorite music? _____

Is there anything you would like for us to know to help us take better care of you?

_____

_____

_____

Who was the special person in your life that died? _____

_____

How long ago? _____

How was the person special to you? _____

What do you miss most about your loved one? _____

_____

_____

_____

Signature