



Camper Application

Camper's Name: _____ Nickname: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ School: _____ Grade: _____ Sex: Male Female

Parent/Guardian's Name: _____

Parent/Guardian's Address (if different than child's/teen's address): _____

City: _____ State: _____ Zip: _____

Home Phone (____) _____ OK to leave a message? Yes No

Work Phone (____) _____ OK to contact you at your workplace? Yes No

Mobile Phone (____) _____ OK to contact you on your mobile phone? Yes No

E-mail _____ What is the best place/time to contact you? _____

Family Members: (Please include all members of the household and any person who is close to the child/teen).

Name	Age/ Relationship	School/Grade/ Occupation	Does this person live in the home with you?	Gender
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F

Has your child/teen ever:

Attended day camp? Yes No

Attended overnight camp? Yes No

Spent the night away from home? Yes No

Does your child/teen know how to swim?

Yes No If yes: Beginner

Intermediate

Advanced

What activities and/or special interests or hobbies does your child/teen enjoy (i.e. sports, arts and crafts, reading, music, dancing, hiking, etc) _____

Have you and your child/teen talked about the possibility of him/her coming to Camp Erin? _____

What would you hope that your child/teen would gain from attending Camp Erin? _____

Is there anything we should know to better serve your child/teen? _____

How did you learn about this program?

Hospice School Physician Friend Newspaper Other: _____

Signature

Relationship to child/teen

Date

Bereavement History

Please 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.

Camper's Name: _____

Full name of person who died: _____ Relationship to child/teen: _____

Birth date of person who died: _____ Date of death: _____

Age of person who died at time of death: _____ Age of child/teen at time of death: _____

Was the person who died receiving HospiceCare Services at the time of death? Yes No

What were the cause and circumstances (what happened and where, who was there, children present) of the person's death?

Was there a funeral or memorial service? Yes No If yes, did your child attend and what were your child's comments/reactions to the service?

What does the child/teen know about the cause and circumstances of the death? _____

Is there anything the child/teen has not been told about the death? _____

Did the child/teen live with the person who died? _____

How would you describe your child's/teens relationship with the person who died? (close, conflicted, ambivalent, inconsistent)

How does your family communicate about the death and the person who died?

- We talk about it often We talk about it rarely We avoid talking about it
 We talk about it sometimes We never talk about it

Comments: _____

Please describe your child's/teen's support system? (i.e. friends, family, church, teams, school, etc) _____

Please describe your family's support system: _____

Signature

Relationship to child/teen

Date

REACTION TO THE LOSS

Please explain how your child/teen shows that he/she is grieving.

Please check the box if your child has exhibited any of the following since the death of the loved one:

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Behavior problems at school | <input type="checkbox"/> Peer difficulties | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Withdrawn/isolation | <input type="checkbox"/> Behavior problems at home | <input type="checkbox"/> Drug/alcohol use | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Running away from home | <input type="checkbox"/> Inappropriate sexual behavior | <input type="checkbox"/> Suicidal thoughts/talk | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Headaches, stomachaches | <input type="checkbox"/> Difficulty with concentration | <input type="checkbox"/> Changes in attendance | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Causing harm to self | <input type="checkbox"/> Destruction of property at school | <input type="checkbox"/> Weight loss or gain | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Causing harm to others | <input type="checkbox"/> Belief that death was his/her fault | <input type="checkbox"/> Always trying to be in control or perfect | <input type="checkbox"/> Disbelief |
| <input type="checkbox"/> Special fears | <input type="checkbox"/> Belief that death is a punishment | <input type="checkbox"/> Loss of interest in usual activities | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Changes in how he/she feels about self | <input type="checkbox"/> Worries about his/her safety or the safety of others | | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Sleeping disturbances (Please circle: Sleep Walking, Bedwetting, Nightmares, Night Sweats) | | | |

Please comment on any of the above issues that concern you. _____

Has your child/teen experienced other death losses (people or pets)? If yes, please complete:

Name	Relationship to Child/Teen	Date of Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How did your child/teen cope with these losses? _____

OTHER IMPORTANT INFORMATION

Is your child/teen currently receiving or has your child/teen ever received any professional support or counseling (i.e. therapist, support group, psychiatrist or pastoral support)? Yes No If yes, what were the circumstances? (Presenting problem? How many sessions? Was it helpful?) _____

Have there been any other changes or stresses in your child's life (i.e. illness, relocation, divorce, remarriage, finances, other losses)? Please explain. _____

Has your child/teen ever experienced abuse of any kind? Yes No If yes, please describe the circumstances and follow-up taken. _____

Please describe your child's/teen's personality/character traits (i.e. easy-going, shy, out-going, takes time to warm up, etc). _____

Are there any language, disability, and/or religious needs that we should be aware of to better serve your child? _____

Are there any other special needs, family customs, or cultural aspects to your child's/teen's grieving that we should be aware of? _____

Signature Relationship to child/teen Date

Medical History

Camper's Name: _____

Who should we notify in case of emergency?		
Parent Name: _____	Relationship: _____	
Telephone: _____	() _____	() _____
Other Name: _____	Relationship: _____	
Telephone: _____	() _____	() _____

Does your child/teen have any of the following:

- | | | |
|--|------------------------------|-----------------------------|
| Physical limitations | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dietary restrictions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Convulsions/Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ear infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing impairment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Motion sickness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nose bleeds | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wears glasses/contacts | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Reoccurring headaches or stomach aches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any history of operations or serious illnesses | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies (i.e. food, medicine, or other) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please specify _____

Date of your child's/teen's latest Tetanus shot: _____

Other medical information: _____

Is your child/teen currently under the care of a physician?	
Dr.'s Name/Phone: _____	Hospital Preference: _____
Health Insurance: _____	Group Number: _____

Will your child/teen be taking medications at camp? If yes, please specify below. Yes No

Name of Medication/Dosage	For what?	Prescribed by:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature

Date

Relationship to child/teen

Please return completed camper applications to: Shelli Worrall, Camp Erin Coordinator
2594 Trailridge Drive East, Lafayette, CO 80026

shelliworrall@hospicecareonline.org