



Dear Prospective Camper and Family,

Thank you for your interest in Camp Erin! Enclosed you will find a registration packet that includes an application containing a bereavement history, medical information, and general interest form.

Camp Erin will be held October 1-3, 2010 at Camp Wondervu located in the mountains, just 45 minutes from the metropolitan Denver area. Please note that parents/guardians are responsible for transporting their camper to and from Camp Wondervu. Families may want to consider carpooling to camp.

While at camp, your child will stay with other campers who are close in age and of the same gender. All activities are overseen by our bereavement staff and trained volunteers who have undergone screening and background checks. Two licensed nurses will be on site throughout the weekend. The camp includes three meals a day, snacks, and a take-home backpack.

Acceptance to the camp will be based on several criteria. Because we want to ensure the best possible experience for every Camp Erin participant, each application will be reviewed in detail and will include an interview before the application process is complete. Bereavement Coordinators will screen campers' applications to determine their appropriateness for this specialized camp prior to final registration. Completed applications will be accepted on a first-come basis. Space is limited and there may be a wait list.

If you would like additional information or to download a copy of our Camp Erin brochure, you may visit our website at [www.hospicecareonline.org](http://www.hospicecareonline.org)

"Save Your Spot" pizza party, September 10, 2010 from 6:00-8:00pm.

If your child is accepted to camp, this will be an important opportunity for you and your child to meet the staff and your child's cabin buddies. There will also be important information for parents provided at this meeting. Please mark your calendars so that if your child is accepted, you can save your spot!

You may either mail or drop off camper applications to me at the address below. If you have any questions or concerns please feel free to contact me.

Thank you again for your interest in Camp Erin!

Respectfully,

Sharon Noe  
Camp Erin Coordinator  
HospiceCare of Boulder and Broomfield Counties  
1585 Patton Dr., Boulder, CO 80303  
(303) 604-5222  
[sharonnoe@hospicecareonline.org](mailto:sharonnoe@hospicecareonline.org)



# 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

# Medical History

Camper's Name: \_\_\_\_\_

Who should we notify in case of emergency?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (    ) (    ) (    ) \_\_\_\_\_

  

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:
_____	_____	_____
_____	_____	_____
_____	_____	_____

# 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?

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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?

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

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

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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)

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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: \_\_\_\_\_

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

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Please describe your family's support system: \_\_\_\_\_

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## REACTION TO THE LOSS

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

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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

Date

Relationship to child/teen

Please return completed camper applications to: Sharon Noe, Camp Erin Coordinator  
HospiceCare of Boulder and Broomfield Counties  
1585 Patton Dr., Boulder, CO 80303