



Help us get to know you....

To be completed by prospective camper

PLEASE PRINT CLEARLY IN BLUE OR BLACK INK

Name _____

I am _____ years old. I am in the _____ grade

My T-Shirt size is **Adult** S___ M___ L___ XL___ Other_____

I am planning to go Camp Good Grief because _____ died.

I want to go to Camp Good Grief because.... (Please mark all that apply)

_____ I miss the person that died.

_____ I would like to meet other kids that have had a special person in their life die.

_____ I would like to learn ways to cope with the death.

_____ My parent/ guardian(s) are making me go.

_____ I would like to get away from home for awhile and have fun with kids my own age.

_____ Other (explain) _____

What are some of your fears about going to Camp Good Grief? Circle all that apply.

_____ I feel uncomfortable about talking with others about death.

_____ I am afraid I won't have anything in common with the other kids.

_____ I don't want to stay away from home.

_____ Maybe the other kids won't like me.

_____ Other (explain) _____

Camper Contract

I agree to follow all rules and regulations set by Camp Good Grief. Failure to follow these rules or regulations, or conduct myself in a manner that will promote a safe and successful experience will result in an immediate return to home.

Camper's Signature

Date

Parent's Signature

Date

To be completed by camper's Parent/Legal Guardian.

****PLEASE PRINT CLEARLY IN BLUE OR BLACK INK****

Camper's Legal Name _____

The name that the camper likes to be called _____

Date of Birth ____/____/____ Age _____

Sex: _____ Male _____ Female

Parent/legal guardian: _____
(Relationship)

Street Address: _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Camper Email Address _____

How do you think this camp would benefit your child?

CAMP GOOD GRIEF BEREAVEMENT HISTORY

Please include as many details as possible when answering the following questions.

(Attach extra pages if necessary.) ****PLEASE PRINT CLEARLY IN BLUE OR BLACK INK****

1. Who was the person who died? (Name) _____
Relationship to child _____ Date of Death _____
Birth date of deceased _____

2. Cause of death _____

3. Age of child at the time of the death _____ Age of the person who died _____

4. What was the relationship like between the child and their loved one who died?

5. Where did this person die? Home _____ Hospital _____ Other _____
Explain: _____

6. Was the child present at the time of death? Explain circumstances. If no, how was the child told about the death?

7. Did the child attend the funeral/memorial service? Yes _____ No _____
Was this the child's choice? _____

8. Has the child received any professional support? (i.e. psychologist, psychiatrist, Pastoral counselor, school counselor) Yes _____ No _____ If yes, how long was professional support provided? _____
Name of therapist _____
Agency _____

9. Have there been multiple deaths of loved ones experienced by this child?
Yes _____ No _____ If "yes", please explain nature of death and relationship of persons who died to the child. (Also include pets)

10. Any other changes/stresses in this child's life? (i.e. divorce, illness, relocation, trauma, friend/family moving out of area, changing schools, involvement with legal system)
Yes____ No____ When did the changes occur?

11. What are your concerns regarding your child's grieving? (eg. School performance, friendships, behavioral changes, loss of interest in activities, sleeping and eating patterns, truancy, fighting, passive, withdrawn, etc.)

12. Please describe your child's personality. (How do they interact or get along with other children? Adults?)

13. How does your child respond to changes in environment?

13. Is this the first time staying away from home? Is this the first time away from home since death occurred?

14. Please list any fears/phobias your child may have:

Return completed application to:
CAMP GOOD GRIEF
Hospice of Huntington
1101 6th Avenue
Huntington, WV 25701

Camper's Name: _____

Name of medicine	Reason for taking med.	When it is given	Amount or dose given	How it is given
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		

Please include all herbal medications and vitamins.

Camper's Name: _____

The following non-prescription (over-the-counter) medications may be used on an *as needed* basis to manage illness and injury.

Cross out those the camper should NOT be given.

Acetaminophen (*Tylenol*)

Diphenhydramine antihistamine/allergy medicine (*Benadryl*)

Calamine Lotion/Aloe

Ibuprofen (*Advil, Motrin*)

Guaifenesin cough syrup (*Robitussin*)

Dextromethorphan cough syrup (*Robitussin DM*)

Generic cough drops/sore throat spray

Bismuth subsalicylate for diarrhea (*Pepto Bismol*)

Calcium Carbonate (*TUMS*)

Cortisone cream

Generic Redness relieving eye drops

Meclizine motion sickness (*Bonine*)

Generic antibiotic ointment

Health History (check any with which the camper has been diagnosed and briefly describe camper's symptoms and

how you treat them at home):

- Constipation/diarrhea _____
- Diabetes _____
- Emotional problems _____
- Fainting _____
- Heart Disease _____
- Menstrual cramps _____
- Nosebleeds _____
- Wears glasses/contacts _____
- Sleeping difficulties (nightmares, fear of dark, bed-wetting, sleep-walking, etc.)

- Asthma _____
- Convulsions/seizures/epilepsy _____
- Hearing impairment _____
- Ear infections _____
- Kidney disease _____
- Motion Sickness _____
- Other _____

Camper's Name: _____

Please list any special dietary needs:

Please list any activities in which the camper should NOT participate:

Immunizations

	Year Primary Series Completed	Year of Last Booster
DTP		
MMR		
Oral Polio		
Tetanus Shot		
Tuberculin (TB) Test		Result:

I give permission for the Camp Good Grief nurse to administer the non-prescription (over-the-counter) medications not crossed out on page 3 of this form on an as needed basis.

Parent/Legal Guardian Signature: _____

I also give permission to authorized personnel to carry out such emergency diagnostic and therapeutic procedures as may be necessary for my daughter/son, and also permit such procedure to be carried out at, and by, the local hospitals in the event that my daughter/son has been taken there for emergency care. I understand that any medical expense will be my responsibility.

Parent/Legal Guardian Signature: _____

Please Print Your Name: _____

Date: _____

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Hospice of Huntington
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Huntington, WV 25701