

CAMPER APPLICATION

Please print clearly in blue or black ink.



Help us get to know you! *To be completed by prospective camper.*

My name is _____

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

My t-shirt size is **Adult** SM MED LG X-LG Other _____

I am planning to go to camp because _____ died.

My favorite thing(s) about the person who died was _____

In my free time, I like to _____

How do you feel about going to Camp Good Grief? Circle all the feelings that apply.



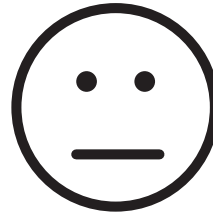
SAD



NERVOUS



HAPPY



OKAY



ANGRY

Tell why you feel this way. _____

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 Signature

Camper Name (Printed)

Date

Parent/Legal Guardian Signature

Parent/Legal Guardian Name (Printed)

Date

CAMPER APPLICATION

Please print clearly in blue or black ink.
To be completed by camper's parent/legal guardian.

Camper's Legal Name _____ Male Female

Name that the camper likes to be called _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____

Parent/Legal Guardian Name _____ Relationship _____

Phone (Home) _____ (Work) _____ (Cell) _____

Parent/Legal Guardian's Email Address _____ Camper's Email Address _____

Bereavement History

Name and age of the person(s) who died _____

Relationship to child _____

Date(s) of death _____

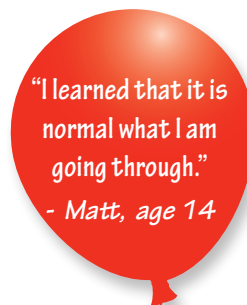
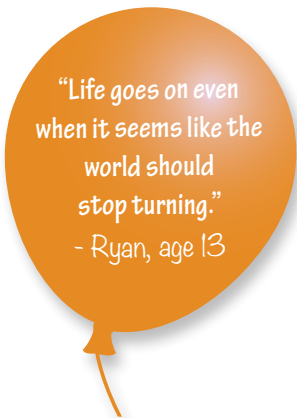
Cause(s) of death _____

What was the relationship between your child and the loved one who died? _____

Was your child present at time of death? _____

Did your child attend the funeral/memorial? _____

Any other changes/stressors in your child's life? _____



Good Grief Camper Health History

Male Female

Camper's Legal Name _____

Name that the camper likes to be called _____

Date of Birth _____

Age on camp arrival _____

Address _____

City _____

State _____

Zip _____

Mother's/Legal Guardian's Name _____

Day Phone # _____

Evening Phone # _____

Father's/Legal Guardian's Name _____

Day Phone # _____

Evening Phone # _____

Physician's Name _____

Phone # _____

In case of emergency and parent/guardian cannot be reached, please notify:

Name _____

Relationship _____

Day Phone _____

Evening Phone _____

Name _____

Relationship _____

Day Phone _____

Evening Phone _____

Allergies No known allergies Allergies, listed below (included all medicine, food, environmental allergies):

Allergic to:	Reaction to Allergy	Treatment/Medicine Taken for Reaction

Medications This camper will NOT WILL take daily medications while at camp

If your child WILL be taking daily medications while at camp, please list below. Include all herbal medications and vitamins.

Name of Medication	Reason for Taking	Time it is Given	Amount/Dose Given	How it is Given
		<input type="checkbox"/> Lunch <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Lunch <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Lunch <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Lunch <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Lunch <input type="checkbox"/> Other _____		

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)

Bismuth Subsalicylate for diarrhea (Pepto Bismol)

Calamine Lotion/Aloe

Calcium Carbonate (Tums)

Cortisone Cream

Dextromethorphan cough syrup (Robitussin DM)

Diphenhydramine antihistamine/allergy medicine (Benadryl)

Generic antibiotic ointment

Generic cough drops/sore throat spray

Generic eye drops for redness relief

Guaifenesin cough syrup (Robitussin)

Ibuprofen (Advil, Motrin)

Medicine motion sickness (Bonine)

Please list any special dietary needs _____

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

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

Parent/Legal Guardian Signature

Parent/Legal Guardian Name (Printed)

Date

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

Parent/Legal Guardian Name (Printed)

Date

RETURN COMPLETED APPLICATION TO:

Camp Good Grief

Hospice of Huntington | 1101 6th Avenue | Huntington, WV 25701