



## Bereavement Camp For Children

### **Camp Nabe sponsored by Hospice Care Registration Materials for Children**

Thank you for your interest in attending this year's Camp Nabe Weekend Camp. The camp is being held on **Friday, July 16<sup>th</sup> through Sunday, July 18<sup>th</sup> at the Preston County 4-H Camp in Bruceton Mills (Preston County).**

Please complete the attached registration form and return it as soon as possible to secure your space. Once your application has been reviewed and accepted, a Hospice Care staff member will interview your child. A confirmation letter which will follow and will include directions, a map of the camp, a list of what to bring to camp and arrival and departure times.

Please note this important information:

- ❖ The registration forms must be completed and signed in order for your child to attend camp. Incomplete information will cause a delay in processing your child's application and may result in your child being unable to attend camp, as space is limited.
- ❖ Each child will be interviewed by a Hospice Care staff member before acceptance into the camp is finalized.
- ❖ If your child requires special accommodations (i.e., dietary restrictions/physical limitations), please let us know immediately. We will make every effort to accommodate special needs.
- ❖ Please plan on bringing your child to camp. Campers will be given an arrival time in the acceptance packet.
- ❖ All campers can attend camp only once, so that others have the same opportunity.
- ❖ Please be sure to read the important information on our request for a media consent and release.

*Please return the registration forms to:*

Chris Garbart  
Project Coordinator  
Hospice Care  
PO Box 760  
Arthurdale, WV 26520  
1-800-350-1161



**Bereavement  
Camp  
For Children**

**Camper Application**

**Camper Information**

Name of Applicant: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Age (at time of application): \_\_\_\_\_ Sex (please circle): Male Female

School: \_\_\_\_\_ Last Grade Attended: \_\_\_\_\_

Where does child reside if different from above.

Address: \_\_\_\_\_

Shirt Size (please circle one): Small Medium Large X-Large XX-Large  
*(Please note that these are adult sizes)*

**Parent/Guardian Information**

Name(s) of Parent(s)/Guardian(s): \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_  
(If different from child)

City/State/Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

**Please list other family members that will be attending the camp this weekend:**

\_\_\_\_\_  
\_\_\_\_\_

I \_\_\_\_\_, give permission to Hospice Care Corporation to share the information in this packet with the Camp Nabe Staff.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPLICATION DEADLINE IS MAY 14, 2010**





# HOSPICE CARE CORPORATION

## CAMP NABE MEDICAL HISTORY AUTHORIZATION AND CONSENT TO TREAT A MINOR FORM

Name of Child \_\_\_\_\_ Birth date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

**Health History:** (check if your child has ever had any of the following medical complications)

Frequent ear infection                       Diabetes                       Epilepsy  
 Mononucleosis

**Allergies:** (check any of the following allergies that pertain to your child)

Asthma                       Food \_\_\_\_\_  
 Hay Fever                       Insect Stings                       penicillin  
 Poison Ivy                       Other Drug \_\_\_\_\_

Will your child be bringing any medication?  No  Yes

If yes, please complete box below:

Name of Medication	Dosage	Times Taken

**ALL MEDICATIONS BROUGHT TO CAMP MUST BE TURNED INTO THE CAMP NURSE AND WILL BE ADMINISTERED BY HER OR HER DESIGNEE.**

Please check over-the-counter medications that may be administered:

- Tylenol                       Ibuprofen                       Cough Syrup                       Decongestant  
 Dramamine  
 Antacid                       Polysporin                       Hydrocortisone                       Artificial tears  
 Other \_\_\_\_\_

I verify that all medications brought to camp are listed on this form and that all medications must be turned in to the Camp Nurse. I authorize the Camp Nurse or designee to administer or dispense medications including over-the-counter medications.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Date of last Tetanus Vaccination \_\_\_\_\_

Activities that should be restricted or physical limitations:

\_\_\_\_\_

**AUTHORIZATION AND CONSENT TO TREAT A MINOR**

I hereby give permission and authorize Camp Nabe staff/designees to provide to: (Camper's name)\_\_\_\_\_ routine health care, first aide, administer prescribed medications, and seek emergency medical treatment; including ordering x-rays or routine tests, and ordering injections and/or surgery. I agree to the release of any records necessary for insurance purposes. I give permission to Camp Nabe to arrange necessary related transportation for the camper. In the event I cannot be reached in an emergency, I hereby give permission to the physician, dentist, or other health care provider selected by Camp Nabe to secure and administer treatment, including hospitalization, for the camper and acknowledge that I will be responsible for the payment of all charges related to the health care services.

Please list medical restrictions (if any):

\_\_\_\_\_  
\_\_\_\_\_

This form may be photocopied for use outside of the camp to secure treatment.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**PARENTAL AUTHORIZATION**

I/We authorize and request Hospice Care Camp Nabe nurse to administer the medication(s) prescribed by our families physician, and in so doing relieve the camp, its agents, employees or representatives of any responsibility for ill effects which may result from administering of said prescribed medication.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*This signed release is required for camp attendance.*

# HOSPICE CARE CORPORATION

## CAMP NABE INFORMED CONSENT, AGREEMENT, RELEASE OF LIABILITY AND PHOTO PERMISSION/RELEASE

### Informed Consent

I hereby give permission for my child, (camper's name), \_\_\_\_\_ to attend Camp Nabe on (dates), \_\_\_\_\_ and I understand that Camp Nabe's goal is to help facilitate the bereavement process of my child and provide support for him/her in expressing feelings of grief.

\_\_\_\_\_ Parent/Guardian Initials

### Parent/Guardian Agreement

I understand that reasonable precautions are taken to insure that all programs and activities are conducted in a safe and responsible manner by Camp Nabe (a program of Hospice Care Corporation, Inc.) staff/designees. I understand and accept that the Camper may be exposed to potential hazards while at Camp and participating in activities including but not limited to the natural setting of the Camp and activity sites, weather changes, plants, and insects.

\_\_\_\_\_ Parent/Guardian Initials

### Waiver and Release of Liability

As parent or guardian of y child, I agree that I will not hold Camp Nabe, (a program of Hospice Care Corporation, Inc.), its employees, officers, directors, volunteers, agents and contractors liable for any personal injury, property damage, loss or insurance. I agree to release and hold harmless Camp Nabe, its employees, officers, directors, volunteers, agents and contractors from all liability incurred as a result of my child's participation in camp, and that these terms serve as a release for myself and members of my family.

\_\_\_\_\_ Parent/Guardian Initials

### Photo Permission and Release

Camp Nabe is granted permission to take and use any group or individual photograph, photo image, recording, or video taken during a camp session for publicity or promotional purposes.

\_\_\_\_\_ Parent/Guardian Initials

\_\_\_\_\_  
Parent/Guardian Name (please print)

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Parent/Guardian Signature



# BEREAVEMENT HISTORY

Child Name: \_\_\_\_\_

NAME	RELATIONSHIP AND OR NON RELATIVES	DATE OF DEATH	AGE	CAUSE OF DEATH	HOSPICE PATIENT  YES OR NO