

# **Camp GOOD GRIEF**

## **A Youth Bereavement Camp**



### **APPLICATION PACKET**

### **FOR CAMP GOOD GRIEF**

A Service of  
**Hospice Care Options  
Foundation**

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*“Caring People, Touching Lives”*

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## General Information

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YOUTH'S NAME

NICKNAME

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MAILING ADDRESS

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CITY

STATE

ZIP

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PHYSICAL ADDRESS (IF DIFFERENT FROM ABOVE)

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CITY

STATE

ZIP

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PARENT'S [GUARDIAN] NAME

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TELEPHONE NUMBERS (HOME, WORK, MOBILE)

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DATE OF BIRTH

AGE

GENDER

RACE

How did you hear about camp? School

Church

Counselor

Newspaper

Friend

Relative

Other: \_\_\_\_\_

T-shirt Size: Youth: S M L  
Adult: S M L XL 2XL 3XL

**Emergency Contact Information:**

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*NAME* *RELATION*

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*PHONE NUMBERS (HOME, WORK, MOBILE)*

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*NAME* *RELATION*

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*PHONE NUMBERS (HOME, WORK, MOBILE)*

**Bereavement History**

1. In what area is the youth experiencing loss?

- Death     Divorce     Fire     Relocation     Other: \_\_\_\_\_

2. Give a brief explanation of the loss and how the youth is coping with the loss.

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### Family Information

Are both parents living?  Yes  No

Who does the youth live with? \_\_\_\_\_ Relation: \_\_\_\_\_

List other family members directly involved in the life of the youth: \_\_\_\_\_

Please give a brief description of the home situation of your youth.

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### Required Health Information *(All health information will be kept confidential)*

Does your child have any health problems/issues that our staff needs to be aware of?

Yes  No If Yes, please explain: \_\_\_\_\_

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Please list any known allergies or dietary restrictions. \_\_\_\_\_

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Also indicate any activities to be encouraged or restricted. \_\_\_\_\_

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**Please list current medications prescribed for your child to take while at Camp Good Grief, the dosage, the purpose of each and the time to be administered.**

<i>MEDICATIONS/DOSAGE</i>	<i>PURPOSE</i>	<i>TIME</i>

**I give permission for a Camp Good Grief nurse to administer prescriptions, first aid and/or medical treatment to my child, \_\_\_\_\_, including over the counter medications such as Tylenol, Pepto Bismol/Maalox when needed.**

\_\_\_\_\_  
*PARENT/GUARDIAN SIGNATURE*

\_\_\_\_\_  
*DATE*

## RELEASE STATEMENT

I/We, \_\_\_\_\_, hereby give permission for our child, \_\_\_\_\_, to attend Camp Good Grief on the designated dates and times. We understand that the camp's goal is to help facilitate the bereavement process of our child and provide support for him/her in expressing feelings of grief.

In consideration of the above named child being granted permission by Hospice Care Options to attend Camp Good grief:

I/We, for ourselves and on behalf of our child, release and discharge Hospice Care Options, their agents, employees, volunteers, officers, directors, successors, and assigns [hereinafter known collectively as "Hospice"] from all claims, demands, actions and judgements which I/We or my/our child ever had or now has or may have against Hospice for all personal injuries, either physical or emotional, known or unknown, and injury to property, real or personal sustained by my/our child's person or property during his or her attendance of Camp Good Grief.

I/We give permission to the Camp Staff to provide follow up support to my child(ren)/ family following Camp in the form of mail outs, phone calls or personal visits.

I/We give permission for my child(ren) to be transported to and from Camp should I not be able to provide transportation and the Camp has arranged a willing party to provide transportation to the Camp.

I/We give permission for our child to be photographed or videotaped during Camp Good Grief [for camp security and during activities]. We understand that these photographs or video tape will remain in the property of Hospice Care Options and they may be now or in the future used for promotional and/or educational purposes.

Yes     No    \_\_\_\_\_ initial

I/We, the undersigned, have read this release and understand all of its terms.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE