Dear Parent/Guardian,

We are happy that you are considering having your child attend Camp Erin San Diego, June 11- 13th, 2010 in Julian California. This weekend overnight camp for children ages 6-17, will include all the usual camp activities as well as engage campers in meaningful activities aimed at facilitating their grieving process. Previous campers have discovered they are not alone in their experience and have found it beneficial to meet other children who are coping under similar circumstances.

Below you will find an application packet for your family. Questions regarding medical, camp and bereavement history are all important as we want to best understand each child's situation, experience and needs.

Please complete and return the following forms:

- Family Application Form A (one per family)
- Camper Application Form B (one per child)
- Medication Form C (one per child if medications will be brought to camp)

Campers are accepted on a first come first served basis, based on receipt of this completed registration packet. The deadline for us to receive the application packet has passed, however, there is still room available, so please send in your application as soon as possible. Send it to: Camp Erin San Diego, 4311 Third Ave, San Diego, CA 92103. If you prefer, fax to 619-278-6320.

Once we receive and process your child's application packet you will receive a call from our camp staff to arrange a time for a pre-camp meeting with you and your child. This meeting will provide time to get to know you and your child and what you have experienced. We will also provide you with information about camp and give you ample time to ask your questions. We want to ensure that camp is a successful and meaningful experience for everyone.

Prior to camp you may want to participate in the other services we have available to you. These include *Grief Street: A Family Bereavement Program* as well as counseling for families and individuals. Please let our camp staff know of your interest in these services when you meet or you can call 619-278-6480 or email us at griefinfo@sdhospice.org if you would like to participate or have questions about our services.

We look forward to meeting with you and your child.

Sincerely,

Liane Fry, LMFT
Program Manager
The Center for Grief Care and Education
The Institute for Palliative Medicine

FAMILY APPLICATION — FORM A

Please complete one Form A for your family

Date:	Parent/Guardian's Name:	☐ Father ☐ Mother ☐ Guardian	Parent/Guardian's Primary Language:

Street Address:	City:	State:	Zip:

Telephone: ( ) ☐ Home ☐ Work ☐ Cell	Telephone: ( ) ☐ Home ☐ Work ☐ Cell	Telephone: ( ) ☐ Home ☐ Work ☐ Cell	Email Address:

Name of person completing these forms, if other than the parent/guardian:	Relationship to family:	Telephone: ( )	Email:

SIBLINGS

Please list all children living in the home

Child #1 Name:	Current Age:	Relationship to parent/guardian:	Applying for camp? ☐ Yes ☐ No
Child #2 Name:	Current Age:	Relationship to parent/guardian:	Applying for camp? ☐ Yes ☐ No
Child #3 Name:	Current Age:	Relationship to parent/guardian:	Applying for camp? ☐ Yes ☐ No
Child #4 Name:	Current Age:	Relationship to parent/guardian:	Applying for camp? ☐ Yes ☐ No
Child #5 Name:	Current Age:	Relationship to parent/guardian:	Applying for camp? ☐ Yes ☐ No

FACTS OF THE DEATH

Name of deceased:	Date of Death:	Age of deceased at death:

Was the deceased receiving San Diego Hospice services at the time of death: ☐ Yes ☐ No	What was the deceased's cause of death?

OTHER INFORMATION

How did you hear about Camp Erin San Diego?

☐ Family/Friend **01**	☐ Ad in Family Magazine **02**	☐ SDHIPM Staff **03**	☐ SDHIPM Hot Sheet **04**
☐ School Flyer **05**	☐ SDHIPM Volunteer **06**	☐ Camp Erin Flyer **07**	☐ Newspaper **08**
☐ SDHIPM website **09**	☐ The Moyer Foundation Website **10**	☐ Other (please specify) **11**	

For demographic purposes, please check the appropriate box:

Gross Family Household Income:

☐ $25,000 or less ☐ $25,001-50,000 ☐ $50,001-75,000 ☐ $75,001-100,000 ☐ $100,001 or greater

Parent/Guardian's Ethnicity:

☐ African American ☐ Asian ☐ Hispanic ☐ White (Non-Hispanic) ☐ Other, specify:

CAMPER APPLICATION FORM B

Please complete one Form B for each child.

Child's Name:

Date of Birth: (MM/ DD/ YYYY) | Gender: ☐ M ☐ F

Child's School: | City/State: | Grade:

Relationship of the deceased to your child: ☐ Mother ☐Father ☐ Grandmother ☐ Grandfather
☐ Sibling ☐ Friend ☐ Other, please specify:

Please check your child's T-Shirt Size:

☐ Youth Small (YS)	☐ Youth Medium (YM)	☐ Youth Large (YL)	☐ Adult Small (S)
☐ Adult Medium (M)	☐ Adult Large (L)	☐ Adult X-Large (XL)	☐ Adult XX-Large (XXL)

For demographic purposes, please check the appropriate box:
What is the racial/ethnicity of your child:
☐ African American ☐ Asian ☐ Hispanic ☐ White (Non-Hispanic) ☐ Other, specify:

BEREAVEMENT HISTORY

Has your child been told the facts about the deceased's cause of death? ☐Yes ☐ No
Please elaborate if checked "no" and/or if your child does not understand the facts about the death.

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Age of your child at time of death:

Was your child present at the time of death? ☐Yes ☐ No

Did your child see the deceased after the death? ☐Yes ☐ No

Is this your child's first experience with death? ☐Yes ☐ No
If no, please comment on other significant deaths your child has experienced.

Was there a funeral or memorial service? ☐Yes ☐ No
If yes, did your child attend and what were their comments/reactions to the service?

Did your child live with the deceased? ☐Yes ☐ No

How would you describe your child's relationship with the deceased?

How would you describe your family's communication regarding the death?
☐ Open ☐ Hesitant ☐ Prefer not to discuss

Does your child speak openly of the person who died? ☐Yes ☐ No

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

BEREAVEMENT HISTORY continued

Reactions to the Loss

Has your child exhibited any of the following since the death? Please check all that apply.

☐ Lack of energy	☐ Behavior problems at school	☐ Peer difficulties
☐ Withdrawn/Isolation	☐ Behavior problems at home	☐ Drug/Alcohol Use
☐ Depression	☐ Running away from home	☐ Causing harm to others
☐ Suicidal thoughts/talk	☐ Headaches, stomachaches	☐ Lying
☐ Difficulty concentrating	☐ Sleeping disturbances	☐ Stealing
☐ Causing harm to self	☐ Sleep walking	☐ Night Sweats
☐ Bedwetting	☐ Inappropriate sexual behavior	☐ Property Destruction
☐ Nightmares	☐ Loss of interest in usual activities	☐ Changes in self perception
☐ Anger	☐ Belief that death was his/her fault	☐ Disbelief
☐ Special fears	☐ Belief that death is a punishment	☐ Decrease in weight
☐ Sadness	☐ Changes in attendance at school	☐ Increase in weight
☐ Hyperactive/Impulsive	☐ Worries about his/her safety or the safety of others	

☐ Frequent memories, dreams, flashbacks of the event/death

☐ Repeated physical or emotional symptoms when reminded of the event/death

☐ Worried about dying

☐ Nervous or jumpy

☐ Avoiding reminders of the death or events around the death

☐ Separation anxiety

☐ Easily agitated, can't sit still, inability to focus/concentrate, hyperactive, impulsive

OTHER IMPORTANT INFORMATION

Please describe your child's personality/character.

Have there been any other significant changes/stressors in your child's life (i.e. illness, relocation, divorce, remarriage, finances, and/or other losses)? ☐Yes ☐ No If yes, please explain:

Has your child ever experienced abuse of any kind? ☐Yes ☐ No If yes, please explain:

Are there any language, disabilities, and/or religious needs that we should be aware of to better serve your child? ☐Yes ☐ No If yes, please explain:

Are there any other special needs, family customs, or cultural aspects to your child's grieving that we should be aware of? ☐Yes ☐ No If yes, please explain:

Has your child attended Camp Erin before? ☐Yes ☐ No

Please describe any other concerns you have about your child.

CAMPER HEALTH INFORMATION

Please note: *If your child will be taking medications at camp (prescription and over-the-counter), the Medication Form (FORM C) will need to be completed*.

Current Issues:	Yes	No	If yes, please elaborate:
Dietary restrictions			
Hearing impairment			
Wears glasses/contacts			
Other physical limitations			
Asthma			
Diabetes			
Allergies			
History Of:	**Yes**	**No**	**If yes, please elaborate:**
Convulsions/Seizures			
Ear Infections			
Nosebleeds			
Headaches			
Stomachaches			
Significant surgery(ies)			
Serious illness(es)			

What is the date of your child's latest Tetanus shot?	Month: Year:
Physician's Name:	Physician's Phone Number:

In case of an emergency, we will first attempt to contact the child's parent/guardian. If the child's parent/guardian is unavailable, we will call the designated alternative emergency contact below.

Alternative emergency contact's name:		Relationship to camper:	
Telephone: ☐ Home ☐ Work ☐ Cell		Telephone: ☐ Home ☐ Work ☐ Cell	
Health Insurance Carrier:		Telephone:	Policy holder's name:
Policy Number:	Group Number:	Signature of policy holder:	

CONSENT FOR MEDICAL TREATMENT

Name of parent/guardian:	Relationship to child:
Name of camper (first, middle, last):	Date of birth (MM/ DD/ YYYY):

As the parent/legal guardian of the above named child, I give full authorization to Camp Erin San Diego staff or agents to secure medical care or treatment for said youth. This treatment may include assistance from the nearest physician, medical clinic, hospital, trained nurse, EMT, or other health care professional in the event of illness or injury that requires immediate attention as determined by Camp Erin San Diego staff.

In the event of an emergency and I cannot be contacted, I give permission to the treating medical institution and/or medical providers to render any medically necessary care for my child. I further authorize Camp Erin San Diego and its agents to disclose any and all information they deem appropriate and as necessary to secure appropriate care for my child. I agree that I am responsible for any such care rendered to my child and will indemnify and hold harmless Camp Erin San Diego for such care or related costs or expenses.

In addition, I, the parent/guardian of the above named child, *(please check one)* ☐ Do ☐ Do Not authorize the Camp Erin San Diego Nurse to administer over the counter medications (including but not limited to, Benadryl, acetaminophen [Tylenol], and ibuprofen [Advil, Motrin]) as needed while at Camp Erin San Diego.

Signature:	Date:

MEDICATION FORM C

Please complete this form if your child is currently and/or will be taking medication(s) while at camp.

I, the parent/guardian of __________________________________ with a Birth Date of (mm/dd/yyyy): _______________ authorize the Camp Erin San Diego Camp Nurse to administer the following medication(s). Conditions for medications stated below have been met.

Signature:	Date:

Prescription Medications *must be in their original containers, bearing the pharmacy label, and have specific instructions for use (camper's name, dosage, # pills inside, prescribing practitioner, pharmacy name and address, filler's initials, serial #). If Epipens are needed, two (2) must be brought to camp.*

Medication Name	Dose	Reason	Side Effects and/or Precautions	Administration Times		
				Friday	Saturday	Sunday
					☐ A.M.	☐ A.M.
					☐ NOON	☐ NOON
				☐ P.M.	☐ P.M.	
				☐ BED	☐ BED	
					☐ A.M.	☐ A.M.
					☐ NOON	☐ NOON
				☐ P.M.	☐ P.M.	
				☐ BED	☐ BED	
					☐ A.M.	☐ A.M.
					☐ NOON	☐ NOON
				☐ P.M.	☐ P.M.	
				☐ BED	☐ BED	
					☐ A.M.	☐ A.M.
					☐ NOON	☐ NOON
				☐ P.M.	☐ P.M.	
				☐ BED	☐ BED	
					☐ A.M.	☐ A.M.
					☐ NOON	☐ NOON
				☐ P.M.	☐ P.M.	
				☐ BED	☐ BED	
					☐ A.M.	☐ A.M.
					☐ NOON	☐ NOON
				☐ P.M.	☐ P.M.	
				☐ BED	☐ BED	

MEDICATION continued

SEVERE ALLERGY

List each medication separately above. Check the relevant box below and sign.

Check the appropriate statement:

❒ This child does **NOT** need to have the medication with him/her at all times (it will be stored in the Camp Nurse Office and administered as indicated above)

❒ This child should have the medication(s) with him/her at all times in their camp pack

Parent/Guardian Signature:

Does the camper recognize the onset of an allergic reaction in order to notify staff upon the occurrence of these symptoms? ❒Yes ❒ No If no, please discuss with the RN at registration.

Describe the past allergic reaction to each allergen:

ASTHMA

List each medication separately above. Check the relevant box below and sign.

Check the appropriate statement:

❒ This child does **NOT** need to have the medication with him/her at all times (it will be stored in the Camp Nurse Office and administered as indicated above.)

❒ This child should have the medication(s) with him/her at all times in their camp pack.

Parent/Guardian Signature:

If a spacer or nebulizer is used for asthma treatments, please note the type.

Type of spacer or nebulizer:

OVER THE COUNTER MEDICATIONS (OTC)

List each medication separately below. *If you plan on sending your camper with Over the Counter Medication, all medications must be in their original containers containing the original label and directions for use. In addition these must be labeled with the* ***camper's name and dose.***

OTC Medication Name	Dose	Reason	Side Effects and/or Precautions	Administration Times		
				Friday	Saturday	Sunday
					☐ A.M.	☐ A.M.
					☐ NOON	☐ NOON
				☐ P.M.	☐ P.M.	
				☐ BED	☐ BED	
					☐ A.M.	☐ A.M.
					☐ NOON	☐ NOON
				☐ P.M.	☐ P.M.	
				☐ BED	☐ BED	
					☐ A.M.	☐ A.M.
					☐ NOON	☐ NOON
				☐ P.M.	☐ P.M.	
				☐ BED	☐ BED	

Please provide any other information you would like the Camp Nurse to know: