



Camp Connect/Children's Bereavement Activity Registration Form

Camper's Personal Information:

Child's Name: Nickname: Address: T-Shirt Size: City: Zip: Phone: Date of Birth: Age: Female Male School: Grade:

Camper's Parent/ Guardian Information:

Parent / Legal Guardian's Name: Address: City: Zip: Home Phone: Work Phone: Cell Phone: Pager:

Emergency Contact: (please list an alternate emergency contact person)

Name: Relationship to child: Home Phone: Cell Phone:

** In the event of a child's illness, injury, accident, or behavior problem, every effort will be made to immediately notify the parent or guardian. Please ensure that you are providing accurate phone numbers where you can be reached during camp.

Insurance Information:

Company Name: Address: City: Zip: Phone: Person Who Insures Camper: Group #: Policy #:

Physician Information: (Needed incase of an Emergency)

Primary Physician : Phone: Other Physician: Phone: Dentist: Phone:

Allergy Information:

Does the camper have any allergies? Drugs Foods Latex Molds/ Fungus
 Pollens/ Trees/ Grasses Other: _____

List ALL medication/ drug allergies: _____

Describe medication/ drug allergic reactions: _____

List ALL food allergies: _____

Describe food allergic reactions: _____

Does the camper require treatment for allergic reactions? Describe and list all medication required, including dose and how it is given.

General Health History: (please check all that apply)

- | | | | |
|-----------------------------------------------------|---------------------------------------------|---------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Exercise Intolerance | <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Difficulty Running | <input type="checkbox"/> Painful Menstrual Cramps |
| <input type="checkbox"/> Unexplained wt loss/ gain | <input type="checkbox"/> Frequent Earaches | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heavy Menstrual Bleeding |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Difficulty Chewing | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Muscle Pain/ Cramps |
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Frequent Vomiting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Night Terrors | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Difficulty Voiding | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Frequent Nosebleeds |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Learning Disabled | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Mentally Disabled | <input type="checkbox"/> Individual Care Needed |
| <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> Glasses | <input type="checkbox"/> Contacts | <input type="checkbox"/> Other: _____ |

Comments: _____

Medication(s) for conditions? If yes, please list.

Camper's Nutrition Information:

Does the camper require a special diet? Yes No Type: _____

How many meals does the camper eat per day? < 3 4 - 5 6 Other: _____

Does the camper require periodic snacks? Yes No Type: _____

Does the camper take vitamin/ iron supplements? Yes No Type: _____

Favorite Foods: _____

Disliked Foods: _____

Does the camper have any difficulty eating? Yes No Describe: _____

Camper's Social/ Developmental Information:

Camper's Age: _____ Developmental Age: _____ School Grade: _____

of adults living with camper: _____ # of siblings: _____ Camper lives at home? Yes No

Describe the way your camper responds to others and reacts to a new environment and people:

- | | | | |
|-----------------|----------------------------------------------|-------------------------------------------------|-----------------------------------------------|
| Temperament: | <input type="checkbox"/> Easy going | <input type="checkbox"/> Average | <input type="checkbox"/> Resistant/ Difficult |
| Attention Span: | <input type="checkbox"/> Pays attention well | <input type="checkbox"/> Limited attention span | <input type="checkbox"/> Attention deficit |
| Anger: | <input type="checkbox"/> Slow to anger | <input type="checkbox"/> Angers easily | <input type="checkbox"/> Temper Tantrums |
| Frustration: | <input type="checkbox"/> Slow to frustrate | <input type="checkbox"/> Average | <input type="checkbox"/> Frustrates easily |
| Stress: | <input type="checkbox"/> Copes well | <input type="checkbox"/> Average coping | <input type="checkbox"/> Difficulty coping |

Describe the behaviors your camper most often exhibits when stressed or faced with a new environment: (Select as many as apply)

- | | | |
|-------------------------------------------|--------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Withdraws/ Hides | <input type="checkbox"/> Sleeps | <input type="checkbox"/> Plays/ Watches TV |
| <input type="checkbox"/> Laughs/ Humor | <input type="checkbox"/> Cries/ whines | <input type="checkbox"/> Rocks |
| <input type="checkbox"/> Talks with peers | <input type="checkbox"/> Talks with adults | <input type="checkbox"/> Other: _____ |

Describe the play behaviors your camper most often exhibits or is most comfortable with: (Select as many as apply)

- | | | |
|-------------------------------------------------|----------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Enjoys watching others | <input type="checkbox"/> Plays alone | <input type="checkbox"/> Plays next to others |
| <input type="checkbox"/> Plays in small groups | <input type="checkbox"/> Participates in team activities | <input type="checkbox"/> Other: _____ |

Please check terms that are appropriate when describing your child:

- | | | |
|----------------------------------------------|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Very social | <input type="checkbox"/> Very Quite | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Open, outgoing | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Problems at school |
| <input type="checkbox"/> Problems at home | <input type="checkbox"/> Makes friends easily | <input type="checkbox"/> Loss of self-esteem |
| <input type="checkbox"/> Clinging, dependant | <input type="checkbox"/> Problems sleeping | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Fearful | <input type="checkbox"/> Guilty |
| <input type="checkbox"/> Problems Eating | <input type="checkbox"/> Relationship difficulties | <input type="checkbox"/> Other: _____ |

Bereavement History: (Please Complete all that apply)

Name of loved one who died: _____
 Date of death: _____ Cause of death: _____
 Relationship to child: _____ Age of child at the time of death: _____

Describe the child's grieving behaviors: (Crying, temper tantrums, talking about loved one, etc.)

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

Where did this person die? Home Hospital Other: _____

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

Did the child attend that funeral/ memorial service? Yes No

Has the child experienced multiple losses (other deaths, divorce, recent move, trauma, etc.)?

No Yes If Yes, please explain: _____

Has the child received any professional support (ie psychologist, psychiatrist, social worker, counselor, pastor)?

No Yes If Yes, for how long: _____

Please describe any important changes that have occurred in your child's life since the death of the loved one (ie relocation, changing schools, divorce, illness, etc.):

PERSON COMPLETING FORM: _____

RELATIONSHIP TO CHILD: _____

Last Name, First Name

Age

**CAMP CONNECT /CHILDREN'S BEREAVEMENT ACTIVITY
WAIVER, INFORMED CONSENT AND RELEASE OF INFORMATION AGREEMENT**

I, _____, hereby give permission for my child, _____, to attend Camp Connect/ Children's Bereavement Activity. I understand that the camp's goal is to help facilitate the bereavement process of my child and provide support for him/her in expressing feelings of grief. In permitting my child to attend Camp Connect/ Children's Bereavement Activity:

I understand that my child will be well supervised. However, I realize children can injure themselves without fault on the part of Covenant Care staff/volunteers. I release Covenant Care from responsibility for injury to my child and hereby certify the information I have given is correct.

If I cannot be reached in an emergency, I hereby give consent for the staff/volunteers of Covenant Care, to administer medication and provide medical and other care for my child, including without limitation, any medical emergency care required. I also hereby give my consent for any transportation deemed necessary or appropriate, in the sole discretion of Covenant Care, in connection with treatment of my child. I also assume full financial responsibility for any and all medical and other expenses incurred for or on behalf of my child while at Miracle Camp or offsite if in connection with medical treatment, and acknowledge, agree, and understand that Miracle Camp shall not be liable for any such expenses.

I give permission to the camp staff to share the information in this application with the volunteers and counselors who will be working with my child.

I understand that my child may be photographed. I understand that these photographs will remain the property of Covenant Care, Inc. and they may now or in the future be used for promotional and/or educational purposes to include social media, television, newspaper, or other printed literature. _____ (initial).

In consideration of Covenant Care permitting the undersigned the privilege of attending Camp Connect /Children's Bereavement Activity, I hereby agree to indemnify and hold harmless Covenant Care

against, of and from any and all claims of any kind or nature, including liabilities, cost, expenses and attorney's fees, growing out of or connected with my child's participation in Camp Connect/Children's Bereavement Activity.

I have read the Camp Connect/ Children's Bereavement Activity rules in the cover letter, understand them, and agree to follow them. I further understand that if these rules are broken, the child may be asked to leave and that the parent or legal guardian will be expected to transport the child from the activity site.

Printed name

Relationship to the child

Signature

Date