WINGS! CAMPER APPLICATION 2017

The staff of Home Health and Hospice Care, Inc. is really looking forward to meeting you. To help you have the best time possible at camp, we would like to know a little about you before you get here! Please complete the form and attach a picture of yourself if possible. Please PRINT.

Last Name, First Name: _____ Sex: _____ Age: _____

Name you like to be called: _____ Date of Birth: _____

Who do you live with? _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone Number: (____) _____ Cell Phone Number: (_____) _____

Parents' Email: _____

Referral Source: _____

3HC may communicate with parents/guardians using this email address (Check one): ☐ Yes ☐ No

T-shirt size (circle one): Youth: S M L XL Adult: S M L XL

What school do you attend? _____ Grade: _____

How did you hear about WINGS Camp? _____

Favorite School Subjects: _____

Hobbies: _____

Sports: _____

Do you like arts & crafts? _____ What are your favorites? _____

Do you have a Faith Tradition? _____

Favorite Entertainers: _____

Favorite Music: _____

Brothers & Sisters and their ages: _____

Do you have pets? _____ How well can you swim? _____

Are there any other special things we should know to make your time at Wings! more comfortable? Please list (include a separate sheet if necessary):

_____

WINGS! CAMPER HEALTH FORM

Please PRINT all information:

CHILD'S INFORMATION:

Name: _____ Likes to be called: _____

Sex: _____ Age: _____ Date of birth: _____

Address: _____

City, State, Zip Code: _____

Phone Number: (____) _____

Parents/Guardians: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Primary Phone Number: (____) _____ home cell work (circle one)

Secondary Phone Number: (____) _____ home cell work (circle one)

In addition to parent/guardian, who may be authorized to pick child up from camp? (Include name, relation to the child, and phone number):

_____

MEDICAL INFORMATION TO BE FILLED OUT BY PARENT OR PHYSICIAN:

Physician's Name: _____ Phone: (____) _____

Address, City, State, Zip: _____

Dentist's Name: _____ Phone: (____) _____

Address: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT WINGS! CAMP:

Special Diet (Please explain reasons and foods): _____

Physical Activity Restrictions (i.e. athletics, running, etc.): _____

Other: _____

Medical Information page 2 for (child's name)**:** _____

Please describe any medical issues in detail and use an extra sheet of paper if necessary.

Allergies (include what the child is allergic to and what the reaction is): _____

_____

Recent operations or serious illness (include dates): _____

_____

Chronic or recurring illness (i.e. ear/throat infections, asthma, headaches, diabetes, convulsions, etc. _____

_____

Psychiatric or behavioral problems (i.e. ADD, ADHD, depression, withdrawn, etc.)*:* _____

_____

Physical handicaps involving hearing, eyesight, or prosthesis: _____

_____

INSURANCE INFORMATION

Is the camper covered by a health or accident insurance policy? ☐ Yes ☐ No

Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone: (_____)_____ Name & Address of employer providing coverage: _____

Policy # / Group # / Subscriber ID: _____

I have listed all pertinent health information for my child or ward, _____. I release Home Health and Hospice Care, Inc. (3HC), its subsidiaries, its employees, and its volunteers from all liability for accidents or illness related to the information included in this certificate or from my failure to list known or impending health challenges that would impact my child or ward's ability to participate in Wings activities.

_____ _____

Parent/Guardian Signature & Relationship Witness

_____

Witness

PARENTAL / MEDICAL RELEASE FORM

I understand that in the case of minor injuries, first aid treatment may be needed while my child or ward, _____, is attending Wings! and will be provided by a registered nurse. The camp nurse RN has my permission to administer Tylenol for minor aches and pains and fever.

I also understand that in the event that emergency hospital treatment is deemed necessary, my child or ward, _____, will be transported to Lenoir Memorial Hospital in Kinston, NC. I authorize treatment in the emergency department if I cannot be reached at the following telephone numbers: (_____)_____ or (_____)_____. I understand that I will assume responsibility for all costs incurred in the provision of medical treatment.

I hereby release Home Health and Hospice Care, Inc. (3HC), its subsidiaries, its employees, and its volunteers from all responsibility for accidents or injuries while participating in activities connected with Wings! Camp.

_____ _____

Parent/Guardian Signature & Relationship Witness

_____ _____

Date Witness

PHOTOGRAPH / STORY / AUDIO-VISUAL RELEASE FORM

I hereby affirm that I am the parent/guardian of: _____
(name of child)

and I give my consent for Home Health and Hospice Care, Inc. (3HC) to use pictures, photographs, news stories, and/or audio-visual of the above mentioned minor for reproduction of the same in any form including marketing, illustration or publication.

Signature of parent/guardian: _____

Printed name of Parent/Guardian: _____

Relationship to child: _____

Address: _____

City, State, Zip: _____

Phone: _____

Date of Signature: _____

Signature of Witness: _____

Signature of Witness: _____

WINGS CAMP GRIEF ASSESSMENT

Name of Parent / Guardian completing assessment: _____

Child's Name: _____

1. Information about loved one:
   a. When did loved one die? _____
   b. Relationship to child: _____
   c. Cause of death: _____
   d. Was the death expected or unexpected? _____
2. Have there been any other losses or major changes? (i.e. change in residence, loss of other friends/family members/pets, economic changes, job loss for parent/guardian, etc.)

   _____

   _____
3. How frequently does your child talk to you or others who are able to be supportive?

   _____ Seldom _____ Once or twice a month
   _____ Once a week _____ Daily
4. How comfortable is your child in accepting help from other people?

   _____ Not at all, refuses help _____ Only in an emergency
   _____ A little reluctant _____ Feels comfortable accepting help
5. Which of the following, if any, is your child having <u>problems with</u> at this point in his/her life? (Check all that apply)

   _____ Sleep difficulties
   _____ Reduced energy
   _____ Change in appetite
   _____ Anxiousness
   _____ Nervousness
   _____ Panic
   _____ Alcohol/drug abuse
   _____ Withdrawal from others
   _____ Crying
   _____ Expressing their feelings
   _____ Accepting the death of the loved one
   _____ Rearranging and building a new life
   _____ Feeling like they don't "fit in"
   _____ Poor concentration
6. Psychological Status: check the feelings your child has experienced since the death:

   _____ Guilt _____ Fear _____ Sadness
   _____ Anger _____ Acting out _____ Lack of feelings
   _____ Helplessness _____ Shock _____ Isolation
   _____ Denial _____ Acceptance _____ Emptiness
   _____ Relief _____ Other: _____

7. Has your child experienced / Is your child experiencing: thoughts of, plans for or attempts of suicide? (Circle all that apply.) If so, how often? _____
8. Has your child experienced / Is your child experiencing: seeing, hearing, or talking to the deceased? (Circle all that apply.)
9. Environment:
    a. Has your child's living situation changed since this person's death? _____
    b. Does your child have support from you, a family member, or a friend? _____
    c. Is your child involved in meaningful activities that they enjoy? If so, what? _____
    _____
    d. Has / Is your child seeing a counselor? _____
10. Spiritual Status:
    a. Did your child attend church before the death?_____ If yes, how often? _____
    b. Does your child have a pastor/church support? _____
    c. What religious beliefs are important to your child? _____
    _____
    d. What is your child's image of God? _____
    _____
11. School information:
    a. What school does your child attend? _____
    b. Has your child's academic performance changed since the death? If so, how?___
    _____
    c. Other interests or hobbies: _____

Is there anything you would like to add that this assessment did not ask? _____

_____

_____

Overall, how do you feel your child has adjusted to the death of his/her loved one? On a scale of one to ten, circle the number that best describes his/her feelings:

Not Well 1 2 3 4 5 6 7 8 9 10 Doing Fine