

WINGS! CAMPER APPLICATION 2022

The staff of 3HC. 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: \_\_\_\_\_

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

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

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**

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

### 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 emergency hospital treatment is deemed necessary, my child or ward, \_\_\_\_\_, will be transported to the local hospital. 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

\_\_\_\_\_  
Date

**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 can 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 problems with at this point in his/her life? (Check all that apply)
 

_____ Sleep difficulties	_____ Withdrawal from others
_____ Reduced energy	_____ Crying
_____ Change in appetite	_____ Expressing their feelings
_____ Anxiousness	_____ Accepting the death of the loved one
_____ Nervousness	_____ Rearranging and building a new life
_____ Panic	_____ Feeling like they don't "fit in"
_____ Alcohol/drug abuse	_____ 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:
- Has your child's living situation changed since this person's death? \_\_\_\_\_
  - Does your child have support from you, a family member, or a friend? \_\_\_\_\_
  - Is your child involved in meaningful activities that they enjoy? If so, what? \_\_\_\_\_  
\_\_\_\_\_
  - Has / Is your child seeing a counselor? \_\_\_\_\_
10. Spiritual Status:
- Did your child attend church before the death? \_\_\_\_ If yes, how often? \_\_\_\_\_
  - Does your child have a pastor/church support? \_\_\_\_\_
  - What religious beliefs are important to your child? \_\_\_\_\_  
\_\_\_\_\_
  - What is your child's image of God? \_\_\_\_\_  
\_\_\_\_\_
11. School information:
- What school does your child attend? \_\_\_\_\_
  - Has your child's academic performance changed since the death? If so, how? \_\_\_\_  
\_\_\_\_\_
  - 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**