



# CAMP CORAL

**PLEASE ATTACH  
PHOTO OF CHILD  
HERE**

## October 9-11 2009 CAMPER APPLICATION

Please complete **ALL** the questions below writing clearly in blue or black pen. **A RECENT PHOTOGRAPH MUST BE ATTACHED TO THE APPLICATION.** If the application is not complete or does not have a photograph attached, the application will not be processed. Deadline for application: **September 11<sup>th</sup>, 2009**

\_\_\_\_\_  
Camper's full name (please print)

\_\_\_\_\_  
Sex

\_\_\_\_\_  
Age

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
School Attended

\_\_\_\_\_  
Grade

\_\_\_\_\_  
T-Shirt child/adult size  
S M L XL

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
City

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Name of Parent/Guardian

\_\_\_\_\_  
Home phone

\_\_\_\_\_  
Cell phone

\_\_\_\_\_  
Name of Deceased (Hospice Patient Yes or No)

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Child referred by

\_\_\_\_\_  
Phone No:

\_\_\_\_\_  
In case of emergency contact

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Phone No

\_\_\_\_\_  
Please list persons allowed to pick-up child

\_\_\_\_\_  
Contact Number

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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## INFORMATION ABOUT

### WHY YOUR CHILD IS COMING TO CAMP

1. When did the death occur? Briefly describe the circumstances of the death (i.e., automobile accident, prolonged illness, suicide, etc.?)
2. If the death occurred prior to last year, what has happened to indicate the child is still grieving for the person? (For example, change in behavior, and/or mood, academic performance, sleep patterns, etc.)
3. Have there been multiple deaths in the family? If so, please explain.
4. In addition to deaths, have there been any important changes in the child's life? (For example, moving to a new home, new city, loss through divorce, etc.)



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## CONSENTS/RELEASE OF LIABILITY

We put together a yearbook that we will distribute sometime after camp. We would like to include the campers' pictures, names and addresses so that they can correspond. In order do this we are requesting your permission.

We are also considering a video/brochure, (i.e., photographing of camper's artwork, use on HospiceCare webpage as well as any other publicity options.) **Campers' names and addresses will not be included in marketing materials.**

I, \_\_\_\_\_ hereby **GIVE** my permission for my child \_\_\_\_\_ picture/address to be printed in the Camp Coral Yearbook, and/or for their appearance in the videotape or other publicity activities.

\_\_\_\_\_  
Parent /Guardian Print Name

\_\_\_\_\_  
Parent /Guardian Signature

\_\_\_\_\_  
Date

I, \_\_\_\_\_ **DO NOT** give my permission for my child \_\_\_\_\_ picture/address to be printed in the Camp Coral Yearbook, and/or for their appearance in the videotape or other publicity activities.

\_\_\_\_\_  
Parent /Guardian Signature

\_\_\_\_\_  
Date

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## RELEASE OF LIABILITY

I, \_\_\_\_\_ parent/guardian, understand and agree that HospiceCare of Southeast Florida, Inc., its Board of Directors, staff, and volunteers are released from any legal responsibility and/or liability for any occurrences of either accidents or illness which may occur during the entirety of Camp Coral activities, to be held on October 9 – 11, 2009

\_\_\_\_\_  
Parent /Guardian Print Name

\_\_\_\_\_  
Parent and/or Guardian Signature

\_\_\_\_\_  
Date



# CAMP CORAL

## MEDICAL INFORMATION

Child's physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Co: \_\_\_\_\_ Policy No: \_\_\_\_\_

Medication(s): \_\_\_\_\_ dose: \_\_\_\_\_ times: \_\_\_\_\_

\_\_\_\_\_ dose: \_\_\_\_\_ times: \_\_\_\_\_

\_\_\_\_\_ dose: \_\_\_\_\_ times: \_\_\_\_\_

5. Many of the camp activities are outdoors; **please provide sunscreen lotion and bug spray.** Does your child have allergies? If so, please note them below and indicate allergic reactions.

Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reactions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_ give permission for the Camp Coral nurse to administer prescriptions and/or

First aid to my child. \_\_\_\_\_

\_\_\_\_\_  
Parent /Guardian Print Name

\_\_\_\_\_  
Parent /Guardian Signature

\_\_\_\_\_  
Date

**NOTE: All medications must be given to the Camp Nurse at Camp Check-in time. All medications must be in prescription containers and clearly marked with the above information. Please be sure to specify if the medications need to be refrigerated. If your child is currently taking Ritalin during the week, please have them take it on this particular weekend as well. If your child has any specific dietary requirements, or food allergies, please note them above.**

Please send your **completed application and photograph** to appropriate address:

Camp Coral -Keys  
HospiceCare of Southeast Florida, Inc.  
91256 Overseas Highway,  
Tavernier, Fl 33037

**A RECENT PHOTOGRAPH MUST BE ATTACHED TO THE APPLICATION**

**DEADLINE FOR APPLICATION: SEPTEMBER 11, 2009**



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## 2009 CAMP CORAL PRE-QUESTIONNAIRE FOR CAMPERS

Name of Camper: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of Deceased: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Death: \_\_\_\_\_

**Please check all of the boxes that correspond to your child's bereavement:**

1. Child's concept of death:

Believes the person fell asleep and cannot wake up

Believes in spiritual/religious "afterlife"

Believes death is reversible

Believes death is permanent

(other) \_\_\_\_\_

2. Was your child prepared for the death of their loved one?

No

Yes (explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Your child's signs/symptoms of grief (please check all that apply)

Crying

Depression

Avoids discussion of death

Anger

(other) \_\_\_\_\_

Longing for lost loved one

Withdrawn

Denial

\_\_\_\_\_

4. Does your child talk about the person that has died?

Yes

No

Sometimes

5. How has your child handled school/work since the death of their loved one?

No changes

Grades are maintained

Grades are declining

Has been acting out in school/work

Attendance has declined

Interest has declined

(other)

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6. Has your child shown signs of physical illness since the death of their loved one?

**Such as physical pain, headaches, stomach pain, change in eating/sleeping habits**

No

Yes (please explain) \_\_\_\_\_

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7. Is your child on any medication presently? And if so, please indicate if the medication has been prescribed since their loved one died.

No

Yes (Please list) \_\_\_\_\_

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8. Has your child been seen by a therapist/counselor/doctor for their bereavement?

Yes

No

If you answered **NO**, would you be interested in utilizing Art Therapy services from our bereavement center?

Yes, please contact me

No, not at this time

Thank you for your cooperation in completing these questions,  
This helps us to better understand your child's individual needs.