Hospice of Michigan

Dear Parent/Guardian,

Thank you for interest in Hospice of Michigan's Camp Good Grief hosted at Camp Newaygo 5333 S. Centerline Rd, Newaygo, MI 49337 on **Monday, June 17, 2019**.

We are excited to offer Camp Good Grief for **free**. This day camp is filled with fun and adventurous camp activities combined with grief support.

Please complete the following **5 required forms** to register for camp:

1.) Hospice of Michigan and Camp Good Grief Registration/Health Form

2.) Camper's Bereavement History

3.) Interview and Photograph Release Form

4.) HOM Consent Form for Minors

5.) Camp Newaygo Participation/Health Form

Important notes:

1.) Forms must be completed for each child.

2.) Your child is not registered until you receive a confirmation email or letter within 2-3 weeks of submitting your forms.

The registration deadline is May 30th, but please note that camp usually fills up before then, so please register soon!!

In order to get to know your child and to give them the best camp experience, we require a phone meeting with parent or guardian prior to camp. On page 5 of the application, you will be able to note a phone number you can be best reached and days/times your available. Please contact me if you have any questions.

Katie Gedraitis, LLPC
Grief Support Services Manager
(231) 845-3423
kgedrait@hom.org

REGISTRATION / HEALTH FORM

CONTACT INFORMATION

Participant's Name: _____
LAST FIRST MI

Gender: ◯ Male ◯ Female Date of birth: _____

T-Shirt Size: **YOUTH** ◯ S ◯ M ◯ L or **ADULT** ◯ S ◯ M ◯ L ◯ XL ◯ XXL

Is there another camper whom you would like to be placed with in the same group? _____

Home address: _____
STREET CITY STATE ZIP

PARENT/GUARDIAN

Name 1: _____
LAST FIRST MI

Phone / Email: _____
HOME PHONE WORK PHONE CELL PHONE EMAIL (REQUIRED)

Name 2: _____
LAST FIRST MI

Phone / Email: _____
HOME PHONE WORK PHONE CELL PHONE EMAIL

Emergency contact other than parent/guardian: _____
LAST FIRST MI

Relationship to child: _____

Phone: _____
HOME PHONE WORK PHONE CELL PHONE

PHYSICIAN

Name of Camper's physician: _____ Phone: _____

Physician Address: _____
STREET CITY STATE ZIP

Private insurance information must be provided, if applicable. Please be advised that, should a participant require medical attention, the participant's parent or legal guardian (and not Hospice of Michigan, Inc.) is responsible for paying any costs not covered by insurance.

HEALTH INSURANCE

Company Name _____ Effective Date _____

Address: _____
STREET CITY STATE ZIP

Phone Number of Insurance Company: _____ Group: _____

Policyholder's Name _____ Policy _____

Policyholder's Address: _____
STREET CITY STATE ZIP

Relationship to Participant _____

(CONTINUED)

MEDICAL CONDITIONS

Please list any other medical conditions or physician limitations of which the camp staff should be aware:

Please explain any mental health or behavioral concerns of which camp staff should be aware:

Has your child received any professional support (i.e. social worker, school counselor, psychiatrist) Yes No
If yes, for how long, and are they still receiving this support?

If you feel your child has any special needs, and requires special accommodations, please provided explanation:

ALLERGIES
Please list any and all allergies, type of reaction and treatment given:

FOOD RESTRICTIONS
Please list any and all food restrictions and other dietary concerns:

(CONTINUED)

MEDICATIONS

Because the above named participant requires medication during camp hours, I request that camp personnel be permitted to give this medication as directed below. I will provide the medication in an original pharmaceutically filled container whose label will clearly indicate the current and correct dosage, the physician's instructions for administration and physician's name. A physician's letter with his/her signature must be obtained prior to camp if the dose to be given at camp is different than that on the original container. This letter must include participant's full name, dosage amount, delivery time(s), and any limitations. Do not repackage drugs or submit another person's medication. This is Michigan law.

Name of Medication: ____________________

Amount to Administer: ____________________

Purpose of Medication: ____________________

How long has been prescribed for camper: ____________________

Time(s) to be given: ____________________

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Name of Medication: ____________________

Amount to Administer: ____________________

Purpose of Medication: ____________________

How long has been prescribed for camper: ____________________

Time(s) to be given: ____________________

PERMISSION TO SEEK MEDICAL TREATMENT

I hereby give permission to the Camp Sponsor, its employees, personnel, nurses, volunteers and agents (collectively, the "Camp Staff") to seek, obtain and approve of any routine medical care and treatment for my child, who is the Camp Participant identified above, as reasonably deemed to be necessary or appropriate by such Camp Staff. Further, in the event I cannot be reached in an emergency, I hereby give the Camp Sponsor and the Camp Staff permission and authorization to seek, obtain and approve of any medical and/or surgical care and treatment, including, but not limited to, x-ray examination, anesthetic, medical, dental or surgical diagnosis, which may be recommended and provided under the general supervision of any physician or surgeon or other authorized and appropriate medical professional, for Participant, which in the reasonable judgment of such Camp Staff is necessary for the health and well-being of Participant during Participant's participation in the Camp. I hereby authorize the Camp Sponsor and the Camp Staff to release all information, including the health information of my child and a copy of this Form, as necessary for such medical care and treatment and/or as necessary for managing the provision of health care at the Camp.

RELEASE AND ASSUMPTION OF RISK

In consideration for allowing the camp participant identified above (the "Participant") to participate in the Hospice of Michigan, Inc. (the "Camp Sponsor") Camp Good Grief (the "Camp"), I, as a parent and/or legal guardian of Participant, and on behalf of Participant, acknowledge and agree to all of the following:

A. I authorize Participant to attend the Camp and participate and engage in any and all of the Camp activities.

B. Prior to the commencement of the Camp, I was made aware of the nature of the Camp and had sufficient opportunity to inquire further. I understand the Camp has inherent risks and I assume, on behalf of Participant, full responsibility for all those inherent risks. (Parents and guardians who do not wish to accept the risks described in this warning should not sign this Form.)

C. While participating in the Camp, Participant is subject to the policies, rules and regulations of the Camp Sponsor and the Camp. Possession of fireworks, explosives, any weapon, illegal drugs or alcohol is prohibited at the Camp and cause for immediate expulsion from the Camp. Further, any Participant repeatedly disobeying Camp or Camp Sponsor policies, rules or regulations may be expelled from the Camp. The Camp Sponsor is not responsible for lost or stolen property.

D. I, on behalf of myself and Participant, release, indemnify and hold harmless Camp Sponsor, and its past, present and future shareholders, members, directors, officers, employees, agents, volunteers, donors, independent contractors and its and their successors, assigns and heirs (collectively, the "Indemnified Parties") from and against any claims, liabilities, losses, damages and/or expenses (including reasonable attorney fees) arising out of the participation of Participant in the Camp, except to the extent caused by the sole gross negligence or intentional misconduct of the Indemnified Parties.

ACKNOWLEDGEMENT

By signing this Hospice of Michigan, Inc. Camp Good Grief Registration/Health Form, I, the parent or legal guardian indicated below, acknowledge that I have read and understand the above information and have completed such Form, and all other forms submitted on behalf of the Participant in connection with the Camp, fully and truthfully. The above agreements are binding upon me and the Participant, and our estates, heirs, representatives and assigns.

_____

Signature of Parent or Legal Guardian Date

Camper's Bereavement History

In order to get to know your child(ren) better and to give them the best camp experience, we require a phone meeting with parent or guardian prior to camp. Please give the best number to reach you and days and times that work for you to talk with Grief Support Service Managers, Katie Gedraitis or Sue Glover.

Phone Number _____Days Available_____

Time of day available _____

To better serve and support your child(ren), please complete this form.

Camper's Name _____

Name of person who died _____

Relationship to the child_____

Date of death_____ Cause of death_____

Are there any details about the loved one's death that would be helpful for us to know?

_____

_____

_____

Did your child attend the funeral/memorial service? If so, what was the child's reaction?

_____

_____

Have there been multiple deaths of loved ones experienced by your child?

◯ Yes ◯ No

If yes, please tell us about the other losses:

_____

Have there been other stressors in the child's life (divorce, remarriage, move)?

_____

How does your child show that he or she is grieving?

_____

As a parent or guardian, how do you address your child's grief? _____

_____

INTERVIEW AND PHOTOGRAPH CONSENT FORM

I hereby grant Hospice of Michigan the absolute right and permission to use and publish images in which I may be included. I also consent to the extraction of information from any interview I might give.

I understand that the images and interview information may be used in whole or in part, in conjunction with my own or a fictitious name.

I waive any right that I may have to inspect or approve the finished product or products. I release, discharge and agree to hold harmless Hospice of Michigan, their legal representatives or assigns, and all persons acting under their permission of authority, from any liability in the use of photos or interviews, and understand that they may be used by Hospice of Michigan without payment.

I, the subject or his/her legal representative, have read the above authorization, release and agreement, and am fully familiar with the contents.

PLEASE PRINT

Date _____ ☐ Check box if signing as an authorized representative for an adult or minor child

Name 1 _____ Signature _____

Name 2 _____ Signature _____

Phone _____ Email _____

Address _____ Date of Service (if applicable) _____

Child(ren):

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

❑ **These images/interview may be used*** ❑ **These images/interview may be not be used**

***Uses may include:** News coverage, TV, print or radio advertising, print and marketing materials, direct mail, fundraising, internal/external website, YouTube/HOM, Facebook.com/HOM, Twitter.com/HOM

This release may be revoked at any time. To do so, call the Director of Marketing and Communications at 888-247-5701 or write: Communications Dept., Hospice of Michigan, 2366 Oak Valley Dr., Ann Arbor, MI 48103. Hospice of Michigan will take action as quickly as possible.

FOR OFFICE USE ONLY

❑ A copy has been given to the subject.* ❑ A copy has been provided to the Communications/Marketing Dept.*

**Both are required*

Hospice of Michigan
Consent Form for Minors

Dear Parents and Guardians,

Hospice of Michigan offers Grief Support Services for our children and teens on the topics of death, dying and loss issues. Our services are educational and provide the opportunity for children to explore and better understand their feelings and thoughts associated with these topics.

It is not the intention of our services to provide therapy. Instead we offer education, companionship and support for children facing the uncertainty of loss and process of grief.

We offer both individual and group sessions for those experiencing a loss. If you would like for your child to participate in our Grief Support Services, please fill out and return this consent form to Hospice of Michigan in the envelope provided.

If you have any questions or concerns regarding this service, please contact your local Hospice of Michigan site or Grief Support Services Manager.

Katie Gedraitis 231-845-3423

Name of Grief Support Services Manager *Phone*

I agree to allow my child _____
to participate in the Grief Support Services offered by Hospice of Michigan.

_____

Parent or Guardian Signature *Today's Date*

PARTICIPATION/HEALTH FORM

This information will be kept in confidence, and is used to help design each program specifically for the group who uses the facilities of Camp Newaygo. Please read thoroughly and fill out this form completely. If you have questions or need assistance, our staff would be glad to help you.

Participant Data:

Name:_____ Telephone:_____

Address:_____

Birth date:_____Age:_____ What group will you attend with?:_____

Emergency Contact (For minors-guardians please):_____

Day Phone:_____ Evening Phone:_____

Emergency Contact Address: _____ Relationship:_____

Health Data:

It is your responsibility to certify your health status when you take part in Camp Newaygo programs.
Please answer yes or no if you have any of the following conditions which would prevent your participation.

Do you have any history of high blood pressure, heart disease or heart problems?	*Yes* ☐	*No* ☐
Do you have any issues related to stress or mental health ?	*Yes* ☐	*No* ☐
Do you have any breaks, strains or pulls or back or neck problems?	*Yes* ☐	*No* ☐
Have you had any surgery or therapy which would prevent your participation?	*Yes* ☐	*No* ☐
Do you have any pulmonary disease or problems catching your breath?	*Yes* ☐	*No* ☐
Do you have any chronic illness?	*Yes* ☐	*No* ☐
Do you require any accommodation to fully participate in any programs?	*Yes* ☐	*No* ☐
Are you currently on any medication which would prevent your participation?	*Yes* ☐	*No* ☐
Do you have any allergies, conditions, or recent first aid which would prevent participation?	*Yes* ☐	*No* ☐

*Any other health concerns:*_____

Health and Liability Release:

I give my permission for my child to participate in all activities as they pertain to his/her program (including water sports, high and low ropes courses, zip line, overnight, and out of camp activities). I understand and assume full responsibility for all risks associated with program activities which include risk or injury and/or death due to acts of God, inclement weather, slipping, falling, insect bites, equipment failure and all other circumstances inherent in outdoor settings. I release Camp Newaygo and all of their employees or agents from any and all liability for use of any image generated which includes, but not limited to, articles, brochures, memory books, videos, television, Internet, newspaper, and magazine advertisements, Internet images, and all other Internet web site usage. I certify that I am in good health and condition to participate in this program. I further certify that Camp Newaygo has been informed of my health issues as they may relate to this program and I agree to accept full responsibility for any emergency medical treatment incurred as a result of my participation. Finally, I agree to hold harmless and free from liability Camp Newaygo and covenant not to sue, including its staff, directors, volunteers or other representatives. **(Further consent for minors)** The parent/guardian of the above said minor accepts full responsibility for all medical costs incurred by accident or otherwise, and **gives full permission to Camp Newaygo to seek and obtain any medical treatment deemed to be necessary by Camp Newaygo Staff and/or volunteers.**

_____ _____
Participant Signature **Date**

_____ _____
Guardian/Parent Signature (Minor Only) **Date**

COMPLETE ALL PAGES.
SIGN AND DATE WHERE INDICATED
AND MAIL TO:

Katie Gedraitis
Hospice of Michigan
5177 US Hwy 10,
Ludington, MI 49431