12/2022

CAMP TREEHOUSE CHILD/TEEN APPLICATION

Camp Date _____________ Camp Name ___________________________________

Mail to: Carilion Center for Grief and Healing, 2017 S. Jefferson St., Roanoke, VA 24014

CHILD/TEEN'S INFORMATION

Child/Teen's Full Legal Name (Last, First, MI) ____

Preferred Name ______________________ Date of Birth ___________ Age _______

Current Grade _________________ School Child/Teen Attends ____

Legal Sex ☐Male ☐Female

Gender Identity ☐Male ☐Female ☐Transgender Male (Female-to-Male) ☐Transgender Female (Male-to-Female)

☐Other _______________________ ☐Choose Not to Disclose

Child/Teen's Pronouns ☐She/Her/Hers ☐He/Him/His ☐They/Them/Theirs ☐Decline to Answer

☐ Other _______________________

Street Address ____ City/State/Zip______________________

Phone (____) _________________________ ☐Home ☐Cell

Parent/Legal Guardian Name(s)____

Street Address (If Different) _______________________________________ City/State/Zip______________________

Phone (____) _________________________ ☐Home ☐Cell ☐Work ☐Other_______________________________

Email Address ____

Preferred Language _____________________ ☐Interpreter Needed Religion _______________________________

Child/Teen's Race/Physical Feature(s) ☐American Indian ☐Asian ☐African American ☐Pacific Islander ☐White

☐ Other _______________________ ☐ Unknown ☐Choose Not to Disclose

Child/Teen's Ethnicity/Culture ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown ☐Choose Not to Disclose

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EMERGENCY CONTACTS

Primary Emergency Contact __________________________________ Relationship to Child/Teen _________________

Primary Phone (____) ___________________________ ☐Home ☐Cell ☐Work ☐Other_____________________

Secondary Phone (____) ________________________ ☐Home ☐Cell ☐Work ☐Other_____________________

Secondary Emergency Contact ________________________________ Relationship to Child/Teen __________________

Primary Phone (____) ___________________________ ☐Home ☐Cell ☐Work ☐Other_____________________

Secondary Phone (____) ________________________ ☐Home ☐Cell ☐Work ☐Other_____________________

Child/Teen's Primary Care Physician ____ Phone ________________

Hospital of Choice ____

Does your child/teen have any animal fears? (Pet therapy may be a component of Camp Treehouse).

____

Parent/Guardian Initials _________

CAMP TREEHOUSE CHILD/TEEN APPLICATION

Please list any sports/interests/hobbies for your child/teen. ____

____

Please list any additional information such as problems with eating, getting along with friends/peers/family members, school attendance, physical limitations.

____

____

____

INSURANCE INFORMATION

Child/Teen's Health Insurance

____

Subscriber Name __________________________ SSN __________________________ Date of Birth ______________

Address (if different from above) _____________________________________

City/State/Zip______________________

Subscriber Number PCP ________________ Effective Date ______________ Group Number _____________

HEALTH HISTORY (mark those that apply)

☐ Attention Deficit Disorder (ADD)
☐ Acquired Immune Deficiency Syndrome (AIDS)
☐ ADHD
☐ Allergies (foods, bee stings, animals)
☐ Asthma
☐ Constipation/Diarrhea
☐ Convulsions/Seizures
☐ Diabetes
☐ Ear Infections
☐ Fainting
☐ Fears
☐ Hearing Impairment
☐ Heart Disease
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease
☐ Menstrual Cramps
☐ Migraines
☐ Motion Sickness
☐ Nightmares
☐ Nosebleeds
☐ Phobias
☐ Sickle Cell Anemia
☐ Special Dietary Needs
☐ Wears Contact Lenses
☐ Wears Glasses
☐ Emotional Problems
☐ Other (please explain)

Child/Teen's Height ________________

Child/Teen's Weight _______________

Food Allergies_____________________________________ Drug Allergies___________________________________

List other significant allergies____

Please describe types of reactions to any allergies listed____

____

Parent/Guardian Initials _________

CAMP TREEHOUSE CHILD/TEEN APPLICATION

Please list any dietary restrictions (physician recommended, religious, etc.)____________________________________

Please provide any information we need to know to safely care for your child/teen ______________________________

____

Last Tetanus shot (date)_____________ Are immunizations current? ☐ Yes ☐ No

Are there any activities your child/teen may not be able to participate in while at camp? Please explain.

____

Please list your child/teen's medications (include dosage and frequency).

____

In the past 3 months, has your child/teen had any of the following?

A serious injury requiring medical attention	☐ Yes	☐ No
An illness lasting longer than one week	☐ Yes	☐ No
A surgical operation or fracture	☐ Yes	☐ No
Medication prescribed to be taken on a regular basis	☐ Yes	☐ No
Inpatient or emergency room treatment in a hospital	☐ Yes	☐ No

Please explain any "yes" answers to the above questions (including dates, problems and treatment).

____

During a child/teen's stay at camp, they often have complaints of not feeling well. This is often due to homesickness and quickly passes. We provide camp nurses throughout the weekend to monitor all campers and to intervene if medical treatment is necessary. In the event that a child/teen is ill, we will contact you to pick up your child/teen from camp.

Should your child/teen complain of a mild problem, may we have permission to give *Children's Tylenol* or *Children's Motrin* or *Regular Tylenol* or *Motrin* in the dosage appropriate for your child/teen's age and weight, if needed?
☐ Yes ☐ No

Should your child/teen require an age/weight appropriate dose of Benadryl for a mild allergic reaction, may we have permission to administer? ☐ Yes ☐ No

The camp will also have a fully stocked First Aid Kit that will include a Bee Sting Kit. Bee Sting Kits are used for those persons who are allergic to bee stings. If your child/teen is stung, the camp nurse will monitor the situation. Should your child/teen begin to show an allergic reaction, the Bee Sting Kit will be used. You will be notified by the nurse immediately of this action. Comment ____

____

T-SHIRT SIZE

Child/Teen ☐ Small (6-8) ☐ Medium (10-12)

Adult ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ 2X-Large

Parent/Guardian Initials _________

CAMP TREEHOUSE CHILD/TEEN APPLICATION

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BEREAVEMENT HISTORY

Please include as many details as possible when answering the following questions.

Name of the person who died____

How was the person related to the child/teen?__________________________

What was the cause of death?________________________________ When did the death occur (date)?____________

Age of the child/teen when the death occurred__________

Where did the person die? ☐ Home ☐ Hospital ☐ Other ____________

Was the child/teen present at the time of death? Please explain the circumstances.______________________________

____

Did the child/teen attend the funeral/memorial service? If so, what was their reaction to or comments about the service?____

Has the child/teen received any professional support (e.g.: school counselor, peer support group, other licensed counselor, psychiatrist)? ☐ Yes ☐ No

If yes, is support currently being provided? ☐ Yes ☐ No

If counseling is no longer is progress, how long was the period of support provided?_______________________

Please explain how the child/teen indicates if they are still grieving____

Have there been multiple deaths of loved ones experienced by this child/teen? If yes, please describe the nature of death and the child/teen's relationship to the other person(s) who died.____

Have there been any other changes/stresses in the child/teen's life (e.g.: divorce, remarriage, relocation, illness)? If yes, please explain.____

What skill(s) do you believe the child/teen is engaging in order to cope with their grief?____________________________

____

How many other children does this child/teen know who have experienced a significant loss?_______________________

____

Please share how you hope Camp Treehouse will benefit your family.____

____

****To the best of my knowledge, the information provided is correct and accurate. In the event of a medical emergency, I understand that every effort will be made to contact myself or the person I have designated as the**

Parent/Guardian Initials _________

CAMP TREEHOUSE CHILD/TEEN APPLICATION

emergency contact. Should neither of us be available, I agree that the camp nurse or the designated representative may secure necessary medical care for my child/teen. I agree to be financially responsible for any care that my child/teen receives. I give permission to Camp Treehouse staff to provide medical care and to transport my child/teen to the nearest medical facility in case of an emergency.

****I understand that the Center for Grief and Healing is not responsible for items lost or stolen or left at camp.**

I (parent/guardian) grant permission for photographs/videos, written evaluation comments or interviews with my child/teen to be used for educational purposes and/or to promote future camps. ☐ Yes ☐ No

I grant permission for photographs/videos, written evaluation comments or interviews with me to be used for educational purposes and/or to promote future the camps. ☐ Yes ☐ No

How did you learn about Camp Treehouse?____

____ ________________________________

Signature Date