CAMP TREEHOUSE CHILD APPLICATION

Camp Date _____

Mail to: Carilion Center for Grief and Healing, 4434 Electric Road, Roanoke, VA 24018

CHILD'S INFORMATION

Child's Full Legal Name (Last, First, MI) _____

Preferred Name _____ Date of Birth _____ Age _____

Current Grade _____ School Child 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'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's Race/Physical Feature(s) ☐American Indian ☐Asian ☐African American ☐Pacific Islander ☐White
☐ Other _____ ☐ Unknown ☐Choose Not to Disclose

Child'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 _____

Primary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Emergency Contact _____ Relationship to Child _____

Primary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Child's Primary Care Physician _____ Phone _____

Hospital of Choice _____

Has your child ever spent a night away from home? ☐ Yes ☐ No

Parent/Guardian Initials _____

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Does your child have any sleep problems/issues (e.g.: sleepwalking, bedwetting, nightmares, attachment to comfort objects such as blanket, etc.)?_____

_____

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

_____

_____

Please list any sports/interests/hobbies for your child. _____

_____

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

_____

_____

INSURANCE INFORMATION

Child'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
☐ 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's Height _____

Child's Weight _____

Parent/Guardian Initials _____

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☐ Kidney Disease

Food Allergies_____ Drug Allergies_____

List other significant allergies_____

Please describe types of reactions to any allergies listed_____

_____

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

Please provide any information we need to know to safely care for your child _____

_____

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

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

_____

Please list your Child's medications (include dosage and frequency).

_____

In the past 3 months, has your child 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'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 is ill, we will contact you to pick up your child from camp.

Should your child 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's age and weight, if needed?
☐ Yes ☐ No

Should your child 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 is stung, the camp nurse will monitor the situation. Should your child begin to show an allergic reaction, the Bee Sting Kit will be used. You will be notified by the nurse immediately of

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this action. Comment _____

_____

T-SHIRT SIZE

Child ☐ Small (6-8) ☐ Medium (10-12)

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

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?_____

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

Age of the child when the death occurred_____

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

Was the child present at the time of death? Please explain the circumstances._____

_____

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

Has the child 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 indicates if they are still grieving_____

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

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

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

_____

How many other children does this child 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 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. I agree to be financially responsible for any care that my child receives. I give permission to Camp Treehouse staff to provide medical care and to transport my child to the nearest medical facility in case of an emergency.**

****I understand that Carilion Clinic 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 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

Parent/Guardian Initials _____