



Camp Forget-Me-Not

in partnership with



The Moyer Foundation

CAMPER APPLICATION

APPLICATIONS MUST BE RECEIVED BY FRIDAY, JUNE 5, 2009

CAMPER APPLICATION CHECKLIST:

- Complete all sections of the Application. Be sure to provide the camper's name at the top of each page of the application.
- A separate application must be completed for each child.
- Return your child's completed application with a **\$5.00 non-refundable application fee** by mail to Camp Forget-Me-Not/Camp Erin DC Application Processing, Wendt Center for Loss and Healing, 4201 Connecticut Ave., NW, Suite 300 Washington, DC 20008. Make checks or money orders payable to: Wendt Center for Loss and Healing. **Applications will not be processed without receipt of the application fee.**
- If the camper will require medication(s) while at Camp, complete the Camper Medication form.
This form must be signed by a physician.
- Keep a copy of your completed application for your records.
- If your child is selected to participate in Camp Forget-Me-Not/Camp Erin DC, you will be required to attend the Parent/Caregiver Orientation Session on Saturday, July 18, 2009 from 10:00 a.m. until 12:30 noon. Please save that date and we will contact you with the details.
- Reserve the dates for Camp, July 31-Aug 2, 2009.

IN THE MEANTIME:

- We will process applications as they are received, and register campers as space allows.
- Camper interviews are required for individuals new to Wendt Center programs. A scheduled appointment will be arranged for interviews. Clients are interviewed to assess for appropriateness and readiness for camp. Applications will not be considered if your child does not show for his/her interview.
- We will contact you with the status of your child's application.
- Caregivers & Family Members may not volunteer the same year that their child attends camp.
- Please feel free to call us at (202) 624-0010 should you have any questions or need assistance in completing your application.

Camp Forget-Me-Not is now associated with Camp Erin DC. Camp Erin DC was created by and is funded in part by The Moyer Foundation. The Moyer Foundation helps to fund, manage, and grow Camp Erin programs nationwide in partnership with local hospice and bereavement organizations.

Camp Forget-Me-Not/Camp Erin DC Camper Application

PART I: PERSONAL INFORMATION (PLEASE PRINT)

Last Name:		First Name:		Middle Name:
Nickname:		Date of Birth:		Age:
School Name:				Grade <u>Next</u> September:
Home Address:				Home Phone: ()
City:	State:	Zip:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent/Guardian Name:			Relationship to camper:	
Day Phone: ()		Evening Phone: ()		
Cellular Phone: ()		Alternate Phone: ()		
Sibling(s) Name(s)			Age	Resides with Camper
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the camper ever spent the night away from home? <input type="checkbox"/> Yes <input type="checkbox"/> No If <u>YES</u> : with relatives <input type="checkbox"/> with friends <input type="checkbox"/>				
Has the camper ever attended a bereavement camp in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and where?				
Who referred you to Camp Forget-Me-Not/Camp Erin DC? <input type="checkbox"/> Flyer <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> Wendt Center Staff Member <input type="checkbox"/> Wendt Center Volunteer <input type="checkbox"/> Website <input type="checkbox"/> Organization/Agency Name _____				

PART II: BEREAVEMENT HISTORY (PLEASE LIST EACH LOSS DUE TO DEATH SEPARATELY)

Name of the person who died:	Cause of Death:	Relation of the person who died to the camper (i.e., mother, brother, friend):	Date of Death:
Use this space to further explain circumstances surrounding the death. <u>Please explain what the camper has been told.</u>			
How old was the camper at the time of death?		Did the camper witness the death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the camper know the details of the death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were the loved one's remains <input type="checkbox"/> Cremated? <input type="checkbox"/> Buried? <input type="checkbox"/> Donated? Was there a funeral/memorial service? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, did the camper attend? <input type="checkbox"/> Yes - If yes, what reactions/comments did the camper have to the service? <input type="checkbox"/> No - If no, why not?			

Last Name:	First Name:	Date of Birth:
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BEREAVEMENT HISTORY CONTINUED

OTHER DEATHS YOUR CHILD HAS EXPERIENCED (DIFFERENT FROM PAGE 1)

Name of the person who died:	Cause of Death:	Relation of the person who died to the camper (i.e., mother, brother, friend):	Date of Death:
Use this space to further explain circumstances surrounding the death. <u>Please explain what the camper has been told.</u>			
How old was the <u>camper</u> at the time of death?		Did the camper witness the death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the camper know the details of the death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were the loved one's remains <input type="checkbox"/> Cremated? <input type="checkbox"/> Buried? <input type="checkbox"/> Donated?	
		Was there a funeral/memorial service? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, did the camper attend? <input type="checkbox"/> Yes - If yes, describe reactions/comments the camper had to the service?			
<input type="checkbox"/> No - If no, why not?			

Please explain how the camper indicates to you that she/he is grieving:

<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Physically aggressive/Fighting	<input type="checkbox"/> Wetting the bed
<input type="checkbox"/> Change in eating patterns	<input type="checkbox"/> Difficulty in school/change in grades	<input type="checkbox"/> Other
<input type="checkbox"/> Verbally aggressive	<input type="checkbox"/> Wants to talk about deceased	_____
<input type="checkbox"/> Does not want to talk about deceased	<input type="checkbox"/> Sleep Issues	_____
<input type="checkbox"/> Difficulty Concentrating	<input type="checkbox"/> Bad Dreams	_____

PART III: PROFESSIONAL COUNSELING SUPPORT (INCLUDE SCHOOL + COMMUNITY BASED SUPPORT)

Has the camper received any professional support (eg: psychologist, psychiatrist, clergy, counselor, support group)? Circle all that apply.

If yes, and the camper is CURRENTLY receiving professional support, please provide the following information:

Month and year support began:	<input type="checkbox"/> Individual Counseling	<input type="checkbox"/> Support Group
Agency:	Counselor's Name:	

If yes, and the camper PREVIOUSLY received professional support, please provide the following information:

Month and year support began:	<input type="checkbox"/> Individual Counseling	<input type="checkbox"/> Support Group
Agency:	Counselor's Name:	

*** If the camper is currently receiving or previously received professional support please complete the Release of Information on Page 4**

Please provide and check off the dates and details for any other losses or stresses the camper has experienced in his/her lifetime (e.g., other loved ones, pets, divorce, move, illness):

<input type="checkbox"/> Change in school	<input type="checkbox"/> Change in housing	<input type="checkbox"/> Illness	<input type="checkbox"/> Self	<input type="checkbox"/> Other
<input type="checkbox"/> Divorce: Date _____	<input type="checkbox"/> Death of pets: Date _____			
<input type="checkbox"/> Foster Care	<input type="checkbox"/> Incarcerated Family Member:	<input type="checkbox"/> Other : _____		
	Who _____	When _____		

Last Name:	First Name:	Date of Birth:
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PART IV: CAMPER HEALTH HISTORY, EMERGENCY CONTACT AND MEDICAL AUTHORIZATION

HEALTH HISTORY

Please check all that apply:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Allergies (specify) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other Illness: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional Issues | <input type="checkbox"/> Physical Limitations | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Seizures | |

Please explain <u>any</u> items that were checked. Provide <u>SPECIFIC</u> information to help us understand your child's health.
List <u>ALL</u> medications the camper is <u>currently</u> taking: <i>Camp staff will hold/lock all medications while at camp for safety reasons.</i>
Is the camper currently under a physician's care for a medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name and phone number of physician:
Is the camper restricted from participating in any physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:

EMERGENCY CONTACT – THIS PERSON MUST BE AVAILABLE WHILE THE CHILD IS IN CAMP

Person to notify in case of emergency:	Relationship:
Daytime phone: ()	Evening phone: ()
	Cellular phone: ()

PERMISSION TO DISPENSE OVER THE COUNTER MEDICINE

I give consent to the nurse of Camp Forget-Me-Not/Camp Erin DC to use her professional medical judgment in determining if my child is in need of an over the counter medicine. I hereby give permission to the camp nurse to dispense appropriately and as needed: Tylenol, Motrin, and/or Benadryl.

Signature: X _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Subject to the conditions set forth below, as the parent/guardian of _____, I consent for the child described herein to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume the liability for any such medical expenses involved. This authorization extends to the child's participation in any activity sponsored by Camp Forget-Me-Not/Camp Erin DC.

Should a medical emergency arise during the child's participation in a Camp Forget-Me-Not/Camp Erin DC activity, I understand that reasonable efforts will be made to contact me or my designated alternate Emergency Contact at the phone numbers provided in this application. If it is believed the child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate Emergency Contact would cause, I consent to the following:

1. the administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or medical facility identified below or chosen by the Camp Forget-Me-Not/Camp Erin Director; and
2. the immediate administration of life-sustaining measures deemed necessary under the circumstances.

Signature: X _____ Date: _____

THIS INFORMATION MUST BE PROVIDED

Name of Preferred Medical Doctor/Facility:	
Address:	Phone Number: ()
Health Insurance Provider:	Name of Policy Holder:
Identification Number:	Group:

Last Name:	First Name:	Date of Birth:
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PART V: RELEASES

1. Parent/Guardian Permission Statement

I certify that I am the parent/guardian of the above named child. The Health History provided in this application is complete and correct to the best of my knowledge. The child described herein has my permission to engage in all prescribed camp activities, except as noted. If s/he appears to be ill, I will not send her/him to Camp. I hereby grant permission to the Camp-Forget-Me-Not/Camp Erin DC staff to share information contained in this application with the volunteer(s) working with the child.

Signature: X _____ Date: _____

2. Liability Release

I understand and agree that Camp Forget-Me-Not/Camp Erin DC, its Board of Directors, Officers, Employees, and Volunteers are released from any legal responsibility and/or liability arising out of any accidents or illnesses which occur during the child's participation in Camp Forget-Me-Not/Camp Erin DC.

Signature: X _____ Date: _____

3. Art Release

I give my consent that all art (visual, written, and performance) produced at Camp Forget-Me-Not/Camp Erin DC can be used and/ or photographed for documentation of therapeutic art programs, education of graduate student interns; Research, presentations, and/ or publication; exhibit or display. I understand that my confidentiality will be protected at all times and that my name and other identifying data will be altered to preserve my identity.

Signature: X _____ Date: _____

4. Publicity Permission

Videotaping and/or photography may occur during Camp activities. I understand that such material may be used in future publicity and/or educational efforts by Camp Forget-Me-Not/Camp Erin DC. In addition, with staff permission and supervision, news media may photograph, videotape, and/or interview some of the children attending Camp. I consent to having the camper's voice and/or image recorded or photographed for use as outlined above.

Signature: X _____ Date: _____

5. Release of Information – COMPLETE IF YOU ANSWERED YES IN PART III OF THE APPLICATION

As the parent/guardian of the above named child, I give my consent to Camp Forget-Me-Not/Camp Erin DC to obtain from:

(Name of Therapist, Psychologist, School Counselor)

(Title/Phone Number)

Information in the child's records and verbal information related to the child's treatment, as appropriate. I have discussed the nature of the information to be released and the purpose for its release with Camp Forget-Me-Not/Camp Erin DC staff. This consent will be in effect for the duration of the child's participation in Camp Forget-Me-Not/Camp Erin DC.

Signature: X _____ Date: _____

Phone: _____



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Custody Release Form

Name of Child Camper: _____

Birth Date of Child Camper: _____

I am the parent or legal guardian of the child camper identified above. I hereby authorized and direct Camp Forget-Me-Not/Camp Erin DC its staff, and/or its volunteers to release the child camper to the following person(s) at the end of Camp Forget-Me-Not/Camp Erin DC for the purposes of transporting home or otherwise assuming custody of the child camper:

Name: _____

Address: _____

Phone Number: _____

Cell Phone Number: _____

If it is necessary for my child to leave Camp Forget-Me-Not/Camp Erin DC before the end of the program due to illness, injury, or behavior issues, and I cannot be reached, I hereby give permission for my child to be released into the custody of the **person identified above**. I understand that Camp Forget-Me-Not/Camp Erin DC may require photo identification of anyone who picks up the child camper, including myself.

I hereby release Camp Forget-Me-Not/Camp Erin DC, its staff, volunteers and representatives from liability for releasing the child camper to the person identify above.

I have read and understood this entire form, and I agree to be bound by the conditions of the agreement.

Signature of Parent/Guardian

Date

TO BE COMPLETED ONLY IF THE CAMPER WILL REQUIRE MEDICATION WHILE AT CAMP

Last Name:	First Name:	Date of Birth:
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PART VI: CAMPER MEDICATION FORM

THIS SECTION OF THE FORM MUST BE SIGNED BY THE PARENT/GUARDIAN

I authorize and request Camp Forget-Me-Not/Camp Erin DC personnel to administer medication(s) as prescribed below by our physician. In so doing, I relieve Camp Forget-Me-Not/Camp Erin DC, its agents, employees or representatives of any responsibility for ill effects which may result from the administration of said prescribed medications

Signature: **X** _____ Contact phone #: _____ Date: _____

**THIS SECTION OF THE FORM MUST BE COMPLETED AND
 SIGNED BY THE PRESCRIBING PHYSICIAN**

(ONLY IF CAMPER IS CURRENTLY TAKING MEDICATIONS, VITAMINS, INHALERS, ASPIRIN)

(Name of Camper) _____ is applying to participate in Camp-Forget-Me-Not/Camp Erin DC, a sleep-away grief camp for youth who have experienced the death of a loved one. The Camp will be held Friday, July 31 through Sunday, August 2, 2009. Please take a few minutes to provide us with information about prescribed medications for this camper.

The following medications must be administered to the above named child during his/her time at Camp Forget-Me-Not/Camp Erin DC:

Medication	Dosage	Instructions (e.g., time(s) to be administered, with water, food, milk)	Side effects which should be observed by Camp personnel	Reasons for not administering medication as prescribed (e.g., vomiting, fever, drowsiness, convulsions)
1.				
2.				
3.				

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

THANK YOU
 PLEASE RETURN COMPLETED FORM TO THE CHILD'S PARENT/GUARDIAN
 FOR SUBMISSION TO CAMP FORGET-ME-NOT/CAMP ERIN DC PERSONNEL
THE ORIGINAL COMPLETED FORM MUST BE RECEIVED BY FRIDAY JUNE 5, 2009.