



Thank you for expressing an interest in your child's participation in the 2020 session of the Wendt Center for Loss and Healing's Camp Forget-Me-Not/Camp Erin DC to be held June 26– June 28, 2020. This Camp was created to support and normalize grief for children and teens that have experienced a death. Please take the time to go through this application carefully and complete all necessary portions.

Camper Criteria

- Has never attended a Wendt Center Grief Camp
- Must be between 7-17 years old
- Must have experienced a death-related loss
- Must live in the Washington, DC Metropolitan area
- Must be willing to schedule and attend an interview/assessment
- Must be able to attend camp: Friday-Sunday (June 26-June 28, 2020)
- Caregiver attendance at a Camp orientation on Saturday, June 6, 2020 – 12:30 - 2:30pm

Application Reminders

- All completed applications must be received by May 1, 2020.
- A separate application must be submitted for each child in a family.
- Each application should include a **\$10.00 application fee**. If this fee prevents your child(ren) from participating in Camp, please contact us at 202-624-0010 x150 or camp@wendtcenter.org. No child will be denied access to camp based on an inability to pay the \$10. Make checks and/or money orders payable to the Wendt Center. We also accept credit card payments by phone.
- Camper interviews are required for individuals new to Wendt Center programs. Camper interviews are used to assess appropriateness and readiness for camp. A scheduled appointment will be arranged for interviews. Applications will not be considered if your child does not show up for his/her interview.
- Applications will be accepted on a first-come, first-served basis. Space is limited so you are encouraged to complete and return your application as soon as possible. Applications will be processed and registered as received.
- We will contact you with the status of your child's application.
- If the camper requires medication(s), it will be necessary to complete the Camper medication form. ****NOTE:** This form must be signed by a physician.
- Caregivers & Family members may not volunteer the same year that their children(ren) attend camp.
- Please feel free to call us at 202-624-0010 x150 or email us at camp@wendtcenter.org should you have any questions or need assistance in completing your application. *Children and teens from military families are invited and encouraged to apply.

Returning Applications (mail, email, fax, drop off)

- 1) Mail: Wendt Center for Loss and Healing, Camp Forget-Me-Not/Camp Erin DC
4201 Connecticut Avenue, NW, Suite 300, Washington, DC 20008
- 2) Email: scan and email applications to: camp@wendtcenter.org
- 3) Fax: Wendt Center for Loss and Healing: 202-624-0062
- 4) Drop Off applications at Wendt NW - 4201 Connecticut Avenue, NW, WDC - Suite 300 OR
Wendt SE - 2041 Martin Luther King Avenue SE, WDC - Suite 234

If your child is selected to participate in Camp Forget-Me-Not/Camp Erin DC, **you are required to attend the Parent/Caregiver Orientation**. This is a meeting to learn more about Camp Forget-Me-Not/Camp Erin DC, and review the Camp schedule, transportation arrangements and expectations. **Please save the date: June 6, 2020 12:30-2:30PM**



Date Received _____

Camp Forget-Me-Not/Camp Erin® DC Camper Application - 2020

PART I: PERSONAL INFORMATION (PLEASE PRINT CLEARLY)

CAMPER'S Last Name:		CAMPER'S First Name:		CAMPER Preferred Name:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans		Date of Birth:		Age <u>AT</u> camp (June 26, 2020):	
Home Address:		Quadrant:		Apt #:	
City:		State:		Zip:	
Parent/Guardian Name:		Relationship to camper:		Primary Phone #:	
Parent/Guardian <u>Email</u> address: (PRINT)		T Shirt Size: CHILD: <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL		ADULT: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/> XXL	
Sibling(s) Name(s)		Age		Lives w/Camper	
				<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 <u>bereavement camp</u> in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and where? _____					
Is the applicant a current Wendt Center Client? <input type="checkbox"/> Yes <input type="checkbox"/> No Therapist Name: _____					
School Name:			Grade NEXT year:		
Does the camper qualify for or receive free or reduced lunch at school? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Who referred you to Camp Forget-Me-Not/Camp Erin DC?					
<input type="checkbox"/> School <input type="checkbox"/> Resilient Scholars Program @ School <input type="checkbox"/> Wendt Center Staff <input type="checkbox"/> Wendt Center Volunteer <input type="checkbox"/> Website					
<input type="checkbox"/> Court Appointed Staff <input type="checkbox"/> Doctor <input type="checkbox"/> Flyer <input type="checkbox"/> Work <input type="checkbox"/> Friend <input type="checkbox"/> Organization/Agency Name: _____					
Is a member of the family in the US Military? <input type="checkbox"/> NO <input type="checkbox"/> Army <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Air Force <input type="checkbox"/> Navy					
If YES- What is their current status? <input type="checkbox"/> Active <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard <input type="checkbox"/> Veteran <input type="checkbox"/> Deceased					
Is your child currently involved with the DC, MD or VA juvenile justice system? <input type="checkbox"/> Yes <input type="checkbox"/> No					



CAMPER'S Last Name:	CAMPER'S First Name:	Date of Birth:
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PART II: BEREAVEMENT HISTORY (PLEASE LIST EACH LOSS DUE TO DEATH SEPARATELY)

Name of the person who died:	Relationship of the Deceased to the Camper: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Great Grandparent <input type="checkbox"/> Cousin <input type="checkbox"/> Friend <input type="checkbox"/> Teacher/Coach <input type="checkbox"/> Other _____	Date of Death:
Cause of Death: <input type="checkbox"/> Natural Causes/Old Age <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Drug Overdose <input type="checkbox"/> Motor Vehicle Collision <input type="checkbox"/> Military Casualty <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		
Was the deceased a significant <u>caregiver</u> of the camper? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Explain what the camper has been told about the circumstances of the death.		
How old was the <u>camper</u> at the time of the death? _____ years old	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	
What reactions/comments did the camper have to the service? <input type="checkbox"/> Camper DID NOT attend service. Please Explain.		

ARE THERE OTHER DEATHS YOUR CHILD HAS EXPERIENCED?

Name of the person who died:	Relationship of the Deceased to the Camper: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Great Grandparent <input type="checkbox"/> Cousin <input type="checkbox"/> Friend <input type="checkbox"/> Teacher/Coach <input type="checkbox"/> Other _____	Date of Death:
Cause of Death: <input type="checkbox"/> Natural Causes/Old Age <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Drug Overdose <input type="checkbox"/> Motor Vehicle Collision <input type="checkbox"/> Military Casualty <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		
Was the deceased a significant <u>caregiver</u> of the camper? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Explain what the camper has been told about the circumstances of the death.		
How old was the <u>camper</u> at the time of the death? _____ years old	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 there was a service, did the camper attend? <input type="checkbox"/> Yes <input type="checkbox"/> No. Please explain reactions.		



CAMPER'S Last Name:	CAMPER'S First Name:	Date of Birth:
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GRIEF REACTIONS:

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

<input type="checkbox"/> DOES NOT want to talk about deceased <input type="checkbox"/> Wants to talk about deceased <input type="checkbox"/> Withdrawn <input type="checkbox"/> Increased anger <input type="checkbox"/> Does not want to spend time w/friends <input type="checkbox"/> Increase in fears <input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Change in eating patterns <input type="checkbox"/> Sleep issues <input type="checkbox"/> Bad dreams <input type="checkbox"/> Wetting the bed <input type="checkbox"/> Crying <input type="checkbox"/> Other reactions: _____	<input type="checkbox"/> Difficulty in school/change in grades <input type="checkbox"/> Physically aggressive/Fighting <input type="checkbox"/> Verbally aggressive <input type="checkbox"/> Self - injurious behavior <input type="checkbox"/> Substance use
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EXPOSURE TO VIOLENCE

Camper has been exposed to violence in their school?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Camper has been exposed to violence in their community?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Camper has been exposed to violence in their home?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

OTHER LOSSES/EXPERIENCES:

<input type="checkbox"/> Adoption <input type="checkbox"/> Bullying <input type="checkbox"/> Change in school (date: _____) <input type="checkbox"/> Death of a pet Date: _____ Pet: _____ <input type="checkbox"/> Deportation of a loved one <input type="checkbox"/> Divorce	<input type="checkbox"/> Inconsistent visitation w/parent <input type="checkbox"/> Parental abandonment <input type="checkbox"/> Illness <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Incarceration of a family member Date: _____ Who: _____ <input type="checkbox"/> Exposure to Domestic Violence	<input type="checkbox"/> Foster care <input type="checkbox"/> Homeless <input type="checkbox"/> Relocation of home <input type="checkbox"/> Sexual assault/abuse <input type="checkbox"/> Involvement in Juvenile Justice Sys <input type="checkbox"/> Other losses _____
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PART III: PROFESSIONAL COUNSELING SUPPORT

<input type="checkbox"/> This camper has NEVER received any type of counseling support. _____ (Parent/Guardian/Caregiver initial here)	This camper HAS received support from a: Check all that apply. <input type="checkbox"/> Therapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> School support group <input type="checkbox"/> School counselor <input type="checkbox"/> Resilient Scholars Program <input type="checkbox"/> Clergy <input type="checkbox"/> Inpatient treatment <input type="checkbox"/> Voices of Now Program
If YES , and the camper is CURRENTLY receiving professional support, please provide the following information:	
Month and year support began: _____ Agency/School: _____	<input type="checkbox"/> Individual Counseling <input type="checkbox"/> Support Group <input type="checkbox"/> Resilient Scholars Prog. <input type="checkbox"/> Psychiatrist Counselor's Name: _____
If YES , and the camper PREVIOUSLY received professional support, please provide the following information:	
Month and year support began: _____ Agency/School: _____	<input type="checkbox"/> Individual Counseling <input type="checkbox"/> Support Group <input type="checkbox"/> Resilient Scholars Program <input type="checkbox"/> Psychiatrist Counselor's Name: _____



CAMPER'S Last Name:	CAMPER'S First Name:	Date of Birth:
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PART IV: 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 child's confidentiality will be protected at all times and that my name and other identifying data will be altered to preserve my child's 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 the Wendt Center for Loss and Healing/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. Communication Release **COMPLETE IF YOUR CHILD IS CURRENTLY RECEIVING COUNSELING SUPPORT.**

I give permission to have information released in my child's records and verbal information related to my 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.

Name of Therapist/Counselor _____ Phone: _____

Signature: X _____ **Date:** _____



CAMPER'S Last Name:	CAMPER'S First Name:	Date of Birth:	Gender:
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PART V: CAMPER HEALTH HISTORY, EMERGENCY CONTACT AND MEDICAL AUTHORIZATION

- | | | | |
|---|--|---|------------------------------------|
| <input type="radio"/> Allergies (Specify) | <input type="radio"/> Cancer | <input type="radio"/> Hearing Impairment | <input type="radio"/> Diabetes |
| <input type="radio"/> Asthma | <input type="radio"/> Heart Problems | <input type="radio"/> Physical Limitations | <input type="radio"/> Epilepsy |
| <input type="radio"/> ADHD/ADD | <input type="radio"/> Emotional Issues
Depression/Anxiety | <input type="radio"/> Seizure/Date of LAST Seizure
_____ | <input type="radio"/> Other: _____ |

My child has <u>NO</u> health related issues: _____ (initials)	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 restricted from participating in any physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe	
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:	

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

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

PERMISSION TO DISPENSE OVER THE COUNTER MEDICINE

I give consent to the medical staff 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 _____ **Date:** _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Subject to the conditions set forth below, as the parent/guardian of _____ (child's name) , 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 COMPLETED

HEALTH INSURANCE PROVIDER:	POLICY HOLDER:
ID NUMBER:	PHONE #:
GROUP:	



CAMPER'S Last Name:	CAMPER'S First Name:	Date of Birth:
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Section VI: Custody Release Form:

I am the parent or legal guardian of the child camper identified above. The **person listed below** is authorized by me to drop off and pick up my child from the camp bus for the sole purposes of transporting home or otherwise assuming custody of the child camper until we are reunified.

Name: _____ Relationship: _____

Address: _____

City _____ State: _____

Contact Number 1 _____ Contact Number 2: _____

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 identified above.

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

X _____
Signature of Parent/Guardian Date

Please check which site your child will be dropped off and picked up from:

DROP OFF FOR CAMP: _____ **NW Site/Lobby: 4201 Connecticut Avenue, NW, WDC 20008**
Departure at 3:15pm – Friday, June 26, 2020
 or
 _____ **SE Site/2041 Martin Luther King Jr. Avenue, SE, WDC 20020**
Departure at 3:15pm – Friday, June 26, 2020

PICK UP AFTER CAMP: _____ **NW Site/Lobby: 4201 Connecticut Avenue, NW, WDC 20008**
Return at 3:00 pm – Sunday, June 28, 2020
 or
 _____ **SE Site/2041 Martin Luther King Jr. Avenue, SE, WDC 20020**
Return at 3:00pm – Sunday, June 28, 2020



CAMPER'S Last Name:	CAMPER'S First Name:	Date of Birth:
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PART VII: CAMPER MEDICATION FORM

**TO BE COMPLETED ONLY IF THE CAMPER WILL REQUIRE MEDICATION WHILE AT CAMP
THIS SECTION OF THE FORM MUST BE SIGNED BY THE PARENT/GUARDIAN**

I authorize and request Camp Forget-Me-Not/Camp Erin DC medical 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, INHALERS, VITAMINS, 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, June 26 through Sunday, June 28, 2020. 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: _____

**PLEASE RETURN COMPLETED FORM TO THE CHILD'S PARENT/GUARDIAN
FOR SUBMISSION TO CAMP FORGET-ME-NOT/CAMP ERIN DC PERSONNEL
THE ORIGINAL COMPLETED MEDICAL FORM MUST BE RECEIVED BY MONDAY JUNE 15, 2020**