CAMP ERIN
MARY BRIDGE CHILDREN'S HOSPITAL
PART OF THE ELUNA NETWORK

Mary Bridge Children's
MultiCare

Bridges Center for Grieving Children

CAMP ERIN® *June 12-14*

CAMPER INFORMATION

CAMPER'S NAME: _____

Nickname (if any): _____ Camper's T-shirt size (please circle)

School: _____ Youth S YM YL

Adult S AM AL AXL AXXL

Home address: _____

City: _____ State/Zip: _____

Age: _____ Date of Birth: _____ Ethnicity: _____ Grade: _____ Sex: M F

Parent's/Guardian's Name: _____

Employer: _____

Daytime Phone: _____ Evening Phone: _____

E-mail: _____ Cell: _____

Siblings: Name Age

_____ _____

_____ _____

_____ _____

Church Affiliation/Preference: _____

Is your child a YMCA member? ❑ Yes ❑ No

Is either parent/guardian an active, reserve, or national guard military member or military veteran? ❑ Yes ❑ No
If so, what branch? _____

Was the deceased an active, reserve or national guard military member or military veteran? ❑ Yes ❑ No If so, what branch? _____

Does the camper applicant qualify for or receive free lunch at school? ❑ Yes ❑ No

PERSON TO CONTACT IN THE EVENT OF AN EMERGENCY AT CAMP:

1. Name _____ Relationship To Child _____
   Daytime Phone Number _____ Evening Phone _____
   Alternate Phone Number _____ Cell Phone _____

2. Name _____ Relationship To Child _____
   Daytime Phone Number _____ Evening Phone _____
   Alternate Phone Number _____ Cell Phone _____

Has your child ever:

spent night away from home? ❑ Yes ❑ No

attended day camp? ❑ Yes ❑ No

attended overnight camp? ❑ Yes ❑ No

had difficulty staying with a group? ❑ Yes ❑ No

Is your child a swimmer?

If yes, indicate level ❑ Beginner ❑ Intermediate ❑ Advanced

Please describe interests and hobbies your child has (ex. music, arts and crafts, sports, etc.): _____

_____

How did you learn about this program?

❑ Hospice ❑ School ❑ Physician ❑ Friend ❑ Newspaper

Other _____

Has your child attended **CAMP ERIN** before? ❑ Yes ❑ No

If so where _____ when _____

Parent/Guardian signature: _____ Date: _____

Relationship to camper: _____

DARREN WENZ, LICSW
CAMP ERIN Coordinator
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BRIDGES
30 years
A Center for Grieving Children

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CAMPER BEREAVEMENT HISTORY

CAMPER'S NAME _____

1. Name of person(s) who died _____
2. Relationship to child _____
3. Date of death _____ Age of deceased at time of death _____
4. Cause of death _____
5. Was the deceased a significant caregiver of the camper? ❑ Yes ❑ No
6. Was your child present at the time of death? ❑ Yes ❑ No
7. Was your child present at the time of death? ❑ Yes ❑ No
8. Did your child view the deceased after the death? ❑ Yes ❑ No
9. Did your child attend the funeral/memorial service? ❑ Yes ❑ No
10. Do you and your child talk about the deceased? ❑ Yes ❑ No
11. Has your child and/or family received counseling? ❑ Yes ❑ No
12. Has the child and/or family attended a support/group program? ❑ Yes ❑ No
13. Was the school notified that your child experienced a loss? ❑ Yes ❑ No
14. Please explain how your child indicates that he/she is grieving _____

_____

_____

14. Has your child experienced any other deaths? ❑ Yes ❑ No

    If so, who _____ when _____

15. Have there been any other changes/stresses in your child's life (i.e. divorce, illness, relocation, etc.)? Please explain

_____

16. Has your child said or done anything recently that has concerned you? If so, what _____

_____

17. Have any details of the death been withheld? _____

_____

Over

18. Has your child exhibited any of the following behaviors since the death?

PLEASE CIRCLE THE NUMBER WHICH BEST REFLECTS YOUR CHILD'S EXPERIENCE:

(1) STRONGLY DISAGREE TO (5) STRONGLY AGREE

				Was this a problem before the death?	
Decrease in communication with parent/caregiver	1	3	5	❑ Yes	❑ No
Stealing	1	3	5	❑ Yes	❑ No
Destruction of property	1	3	5	❑ Yes	❑ No
Run away from home	1	3	5	❑ Yes	❑ No
Shown signs of self harm	1	3	5	❑ Yes	❑ No
Caused harm to others	1	3	5	❑ Yes	❑ No
Unusual/inappropriate sexual behavior	1	3	5	❑ Yes	❑ No
Drug/alcohol use	1	3	5	❑ Yes	❑ No
Depression	1	3	5	❑ Yes	❑ No
Bed wetting	1	3	5	❑ Yes	❑ No
Special fears	1	3	5	❑ Yes	❑ No
Regression	1	3	5	❑ Yes	❑ No
Behavior problems at home	1	3	5	❑ Yes	❑ No
Behavior problems at school	1	3	5	❑ Yes	❑ No
Ongoing sleep disturbance/nightmares	1	3	5	❑ Yes	❑ No
Changes in family relationships at home	1	3	5	❑ Yes	❑ No
Changes in peer relationships at school	1	3	5	❑ Yes	❑ No

19. Have you and your child talked about him/her coming to **CAMP ERIN**? ❑ Yes ❑ No

20. What, if any, concerns do you have about your child coming to camp? _____

_____

21. What, if any, concerns does your child express? _____

_____

22. Other comments you wish to make: _____

_____

Parent/Guardian signature: _____ Date: _____

Relationship to camper: _____

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CAMPER MEDICAL INFORMATION

CAMPER'S NAME: _____ Date of Birth: _____

Address: _____ Phone: _____

Does the camper have any of the following:

Physical Limitations	❑ Yes	❑ No	Hearing Impairment	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Motion Sickness	❑ Yes	❑ No
Convulsions/Seizures	❑ Yes	❑ No	Nosebleeds	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Wears glasses/Contacts	❑ Yes	❑ No
Dietary Restrictions	❑ Yes	❑ No	Sleep Problems	❑ Yes	❑ No

Other (please specify)

_____

Camper's Height: _____ Weight:_____

Who is your child's regular physician or clinic?

Physician's/Clinic's name: _____ Phone: _____

Is your child currently under the care of a counselor/mental health professional?
❑ Yes ❑ No Name: _____ Phone: _____

Is your child allergic to any medication? ❑ Yes ❑ No

If yes, what medication: _____

Is your child allergic to anything else? ❑ Yes ❑ No

If yes list the allergy and reaction: _____

Does your child have an Epipen? ❑ Yes ❑ No

If so please bring it to camp: _____

Date of your child's latest Tetanus shot (Required)? _____

Any dietary restrictions (vegetarian, food allergies)? _____

Emergency contact name during camp _____

Phone: _____ Cell:_____

Emergency contact name during camp _____

Phone: _____ Cell:_____

Please complete medication information on back of form.

Over

CAMPER MEDICATION INFORMATION

Does your child currently take medications? ❑ Yes ❑ No

Please list all of your child's current medications:

Name of Medication/Dosage: _____ For What? _____

Prescribed by: _____ Phone: _____

Name of Medication/Dosage: _____ For What? _____

Prescribed by: _____ Phone: _____

Name of Medication/Dosage: _____ For What? _____

Prescribed by: _____ Phone: _____

Name of Medication/Dosage: _____ For What? _____

Prescribed by: _____ Phone: _____

Will your child be taking medications at camp? If yes, please specify: _____

_____

_____

_____

_____

Parent/Guardian signature: _____ Date: _____

Relationship to camper: _____

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