Mary Washington
Grief Support Services

Camper's Name _____

Dear Parent/Guardian,

Thank you for your interest in Camp Rainbow. Camp Rainbow is a bereavement camp for children ages 5 to 12 years who are grieving the death of a loved one. Camp Rainbow is a fun morning filled with activities focused on helping your child find healthy and positive ways to deal with their loss. It is offered to children residing in Fredericksburg, Stafford, Spotsylvania, King George, and Caroline County at **no charge**. Snacks and activities are provided.

Camp RAINBOW
A Grief Retreat for Children

Camp Rainbow Activities Include:

- canoeing
- group sharing
- crafts
- art-based activities
- games
- journaling
- remembrance activities
- music therapy
- pet therapy

If you anticipate your child having difficulty participating in the activities listed above, please let us know and we may be able to make other arrangements for them.

This year, Camp Rainbow will be held on **Sunday, October 5 from 9:00 a.m.–12:00 p.m. at Mott's Run Reservoir (6600 River Road Fredericksburg, VA 22407).** Parents/guardians are responsible for dropping off and picking up their child at the time stated above. We are unable to transport campers.

Due to the high volume of applications received, space is limited to a first-come, first-served basis with priority given to children who have not attended camp in the past and children who are involved in our ongoing programming. Please complete all forms and return the entire packet to the email address below as soon as possible. For questions or concerns, please contact Mary Beaven, LCSW at 540.205.0502.

Email: griefsupport@mwhc.com

Applications are due no later than September 26, 2025.

PLEASE NOTE: To help ensure the well-being of all our campers, we kindly ask that your child does not attend Camp Rainbow if they are feeling unwell or have experienced symptoms of illness (such as fever, cough, sore throat, or other flu-like symptoms) within the past 48 hours. We appreciate your understanding and cooperation in keeping our community safe and healthy.

Mary Washington
Grief Support Services

Camper's Name _____

Application Check List

Please make sure the following have been completed prior to submitting:

- ✓ Camper Application (pgs. 3-8)
- ✓ Releases (pg. 9)
- ✓ Authorization to Administer Prescribed Medication Form
  ****Complete only if your child must take medication during the hours of Camp Rainbow. (pgs. 10-11)****
- ✓ Pre-Survey (pg. 12)
- ✓ Consent to Photograph/Interview Release Form (pg. 13). This form must be witnessed by another adult!

Mary Washington
Grief Support Services

Camper's Name _____

CAMPER APPLICATION

In order to provide a safe, healthy, learning environment for children, it is important that you respond to all questions accurately and to the best of your knowledge.

1. PERSONAL INFORMATION (PLEASE PRINT)

Camper's Name_____ ❑ Male ❑ Female ❑ Other _____
Race_____Date of Birth____/____/____ Age_____
Child's address_____

_____
City State Zip County

Parent(s)/Guardians(s) Names_____
Address if different from above:_____

_____
City State Zip
Parent/Guardian(s) Phone #_____Cell #_____
Parent(s)/Guardian(s) e-mail address(es)_____

Emergency Contact – You or another adult must be available while your child is in camp.
Name _____Phone #_____
Address_____
Relationship to child_____

Please list those authorized to pick up your child below. Include the relationship to the child and the best daytime phone number for this person. If there is a specific relative that is NOT authorized, appropriate custody/legal paperwork or permission must be provided.

_____
_____
_____

Child's School _____Current Grade_____
Other Languages Child Speaks_____

Camper's T-Shirt Size: **Youth** ❑ S ❑ M ❑ L ❑ XL **Adult** ❑ S ❑ M ❑ L ❑ XL
Child's Height_____ Child's Weight_____

Mary Washington
Grief Support Services

Camper's Name _____

Physician's Name _____ Phone #_____

Medical Insurance Information (Name and ID number) _____

_____

Is the camper restricted from participating in physical activities? ❑ Yes ❑ No
If yes, please explain: _____
Does the camper have any food restrictions/allergies? ❑ Yes ❑ No
Please list:_____

How did you hear about Camp Rainbow?_____

_____

Has your child ever attended a grief camp? ❑ Yes ❑ No
If yes, where and when_____

_____

Has your child attended a Kids Helping Kids Grief Club in school?
❑ Yes ❑ No Which School:

Mary Washington
Grief Support Services

Camper's Name _____

2. INFORMATION ABOUT YOUR CHILD'S LOSS

Name of the deceased:_____

Relationship to the child: _____Date of Death:_____/_____/_____

Age of deceased:_____ Did this person receive Mary Washington Hospice care? ❑ Yes ❑ No

Place of death: ❑ Home ❑ Hospital ❑ Other _____

Cause of death: ❑ Illness ❑ Accident ❑ Homicide ❑ Suicide ❑ Overdose ❑Other_____

Explain the circumstances: _____

_____

Was the child present at the time of death? ❑ Yes ❑ No

Does the child know the details of the death? ❑ Yes ❑ No

Did your child attend the funeral/memorial? ❑ Yes ❑ No
If no, please explain_____

_____

If yes, explain the child's reaction to the service:_____

_____

Was this your child's first experience with death? ❑ Yes ❑ No
If NO, please provide additional details in Section 3

Camper's Name _____

3. PREVIOUS LOSSES

Relationship	Date of Death	Cause of Death

4. GENERAL QUESTIONS ABOUT YOUR CHILD'S PRESENT BEHAVIOR

If your child has shown any of the following behaviors, please place a "✓" in the column(s) that best answers the question.

General Observations/Behaviors	before death	after death	now	not at all
Worried about his/her safety or the safety of loved ones				
Feeling nervous or anxious				
Hostile behavior towards others – yelling, biting, hitting, swearing				
Lack of concentration or memory				
Sleep difficulties – sleep walking, disturbing dreams/nightmares, bed wetting, inability to sleep				
Self-inflicted injuries or accidents				
Lack of interest in day-to-day activities				
Expressing thoughts of loneliness or isolation				
Expressing suicidal thoughts				
Has the child been in therapy?				

Have there been other changes or stressors in the child's life (divorce, illness, relocations, etc.)? If so, please explain._____

_____

Mary Washington
Grief Support Services

Camper's Name _____

Which of the following activities have been helpful to your child:

- ❑ Talking with a friend
- ❑ Writing or drawing
- ❑ Physical activity/sports
- ❑ Talking with family
- ❑ Talking or writing to the deceased
- ❑ Visiting the gravesite
- ❑ Talking with other supportive person (i.e., minister, teacher, etc.)
- ❑ Other _____

_____

_____

_____

Does your child interact well with peers? ❑ Yes ❑ Sometimes ❑ No
Does your child interact well with adults? ❑ Yes ❑ Sometimes ❑ No

If "No", please include additional information.

_____

_____

To help us make this camp experience meaningful for the child, would you like to share any other pertinent information about the child with us?

_____

_____

To the best of my knowledge the above information is correct and accurate.

_____

Signature of Parent/Guardian Date

Camper's Name _____

5. INFORMATION ABOUT YOUR CHILD'S HEALTH

Does the camper have any disabilities, allergies, asthma, health concerns, etc. that we should be aware of? If yes, please list below. If you would like to speak directly to staff about this matter, please call Mary Beaven, LCSW at 540.205.0502.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Mary Washington
Grief Support Services

Camper's Name _____

RELEASES

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 Camp Rainbow activities, except as noted. If they appear to be ill, I will not send them to Camp Rainbow. I hereby grant permission to Camp Rainbow staff to share information contained in this application with the volunteer(s) working with the child.

Signature of Parent/Guardian Date

Release of Liability

I understand and agree that Mary Washington Hospice and Grief Support Staff and Volunteers are released from any legal responsibility and/or liability for negligence real, implied, or imagined, arising out of any accidents or illnesses which occur while my child is attending Camp Rainbow. Camp Rainbow is not intended to be a substitute for specific individual advice or counseling. Accordingly, consultation with a competent professional advisor is strongly recommended, if needed.

Signature of Parent/Guardian Date

Authorization for Medical Treatment

If a medical emergency occurs during my child's participation in Camp Rainbow, I consent to medical treatment and/or emergency care for my child/ward and for my child being transported to the nearest medical facility, Mary Washington Hospital, for treatment.

Camp Rainbow officials will notify me of this decision. I have provided the Camp Rainbow officials with a number at which I can be reached and authorize the Camp Rainbow officials to contact the physician named below if needed.

Name of Doctor Phone #

Name of Parent/Guardian (Print) Phone #

Signature of Parent/Guardian Date

Mary Washington
Grief Support Services

Camper's Name _____

AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION

COMPLETE ONLY IF CHILD MUST TAKE MEDICATION DURING CAMP RAINBOW HOURS

Part 1 – TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize the person (RN) responsible for rendering first aid and medication administration at Camp Rainbow to administer prescribed medication as directed by the physician (Part II below). I agree to release, indemnify, and hold harmless Mary Washington Healthcare/Grief Support Services and its officers, staff members, or agents from lawsuit, claim, demand, or action etc. against them, for administering prescribed medication to this child, provided Grief Support Services staff are following the physician's order as written in Part II below. I have read the procedures outlined on the back of this form and assume the responsibilities as required.

Name of Child: _____ Birth date:_____/_____/_____

Prescription: ☐ Renewal ☐ New The last dose was given at home on: _____

List all medication(s) being taken, including over-the-counter medications. _____

_____

_____

_____

Parent/Legal Guardian Signature Phone Date

PART II – TO BE COMPLETED BY THE PHYSICIAN

Only non-parenteral medications can be administered. Please use a separate form for each medication.

Name of Medication: _____ Diagnosis: _____
Trade name and/or generic

Dosage: _____ Times(s) to be given: a.m._____p.m._____

Method of Administration: _____Effective Dates: From: _____/_____/_____To: _____/_____/_____

Side effects:_____

If PRN, specify: When indicated_____

Frequency of administration:_____

_____

Physician's name (Print or type)_____
Phone #

_____

Physician's Signature Date

Mary Washington
Grief Support Services

Camper's Name _____

PART III – TO BE COMPLETED BY THE REGISTERED NURSE AT DROP-OFF

Check as appropriate.

☐ Part I and II above are completed. ☐ Prescription medication is properly labeled by a pharmacist.

☐ Medication label and physician orders are consistent

☐ Over-the-counter medication is in original container with the manufacturer's dosage label and safety seal intact. All unused medications will be collected by the nurse at the end of camp.

_____

RN Signature Date

INFORMATION AND PROCEDURES

1. No medication will be administered during the camp without the parent/legal guardian's written authorization and a written physician's order. This includes both prescriptions and over-the-counter medications.

2. The parent/guardian is responsible for completing Part I and obtaining the physician's statement on Part II.

3. The medication must be delivered to the Camp by the parent/legal guardian or, under special circumstances, an adult designated by the parent/legal guardian. Medications brought by a child will not be administered by the RN.

4. All prescription medications must be provided in a container with the pharmacist label attached. Nonprescription over-the-counter medication must be in a container with the manufacturer's original label. Physician samples must be appropriately labeled by the physician.

5. The parent/legal guardian is responsible for collecting any unused portion of the medication at the end of the Camp weekend. Any medication that is unclaimed will be destroyed.

6. Medications without accompanying physician's orders and parental consent will not be stored in the health room. Campers are not permitted to self-administer medications under any circumstances.

Mary Washington
Grief Support Services

Camper's Name _____

Camper Pre-Survey

To better track our impact, we ask you to complete this survey based on the goals of Camp Rainbow. We will ask you to complete a post-survey a few weeks after Camp Rainbow, to see if your child showed any improvement in the following:

Please use the following scale to rate your child's current ability to do the following to the best of your knowledge:

1= Not at all/none 2= A little/sometimes 3= A lot/often

1. Does your child understand what grief means? 1 2 3

2. Is your child able to express his/her thoughts/feelings about their loss? 1 2 3

3. Is your child coping with their loss in a healthy way? 1 2 3

Please write any additional comments about your child's current ability in reference to the survey questions: _____

_____

_____

□ Mary Washington Hospital □ Stafford Hospital □ _____
(MWHC Facility)

Occasionally, hospitals or healthcare providers make and use photographic, video, electronic, audio media or interviews of patients for external and internal use other than the identification, diagnosis, or treatment of the patient (for example, performance improvement, education, commercial filming, television programs, or marketing material).

I, _____, consent to having photographic, video, electronic, audio media or interview of myself, my child(ren), or for the person(s) for whom I am responsible conducted on:

_____ by _____
(Date) (Photographer/Interview)

I also consent to the use of this media in:

_____
(Name of publication, education or audio-visual program)

I consent / decline (circle one) that my first name, the first name of my child(ren) and/or the person(s) for whom I am responsible be shared for the use in the publication, education or audio-visual program listed above.

I consent / decline (circle one) to having friends, family and/or the caregiver interviewed regarding my condition, the condition of my child(ren), and/or the condition of the person(s) for whom I am responsible.

I consent / decline (circle one) to having general information regarding my condition, the condition of my child(ren), and/or person(s) for whom I am responsible released by a Mary Washington Healthcare spokesperson, and if applicable, to law enforcement personnel conducting official investigations.

I hereby release Mary Washington Healthcare, its subsidiaries, its personnel, my friends, family, caregiver and any persons participating in my care, the care of my child(ren) or the care of the person(s) for whom I am responsible from any and all liability that may or could result from the taking or the use of this media, release of general information by a Mary Washington Healthcare spokesperson and release of information to law enforcement personnel.

_____ _____
Patient's Signature Date/Time

_____ _____
Witness Signature Date/Time

*Note: If the above patient is an unemancipated minor (under the age of 18), the above consent is given on the patient's behalf by:

_____ _____
Closest relative or legal guardian Signature Date/Time

_____ _____
Witness Signature Date/Time

C 0 0 6 0 5

Mary Washington Healthcare

Consent to Photograph/Interview ROI

FR-37-MWHC REV. 1/2010

PATIENT IDENTIFICATION
1 1/4" X 3"

Mary Washington
Grief Support Services

Camper's Name _____

For office use only: Date application received _____

Camper's Name_____ ❑ **Male** ❑ **Female** **Age**_____

Date of Birth____/____/____

Big Buddy _____**Group** _____

Allergies _____

Medical Issues_____

For Your Information

✂----------✂-Please save-✂----------✂----------

- A separate application must be completed for each child.
- Please reserve the date for Camp (October 5, 2025)
- We will process applications as they are received. Space is limited so please return the application(s) as soon as possible-**no later than September 26, 2025**. Our intent is to include all applicants in the camp experience; but we may need to "wait list" a child for another event. Priority will be given to children who have never attended Camp Rainbow before, and to those already involved in our programming.
- We will contact you with the status of your child's application. Please be sure to include your email address.
- Please feel free to contact Mary Beaven, LCSW at 540.205.0502 if you have any questions or need assistance in completing the application.
- Please complete the "**Authorization to Administer Prescribed Medication**" form ONLY if the child requires medication(s) while at camp.