CAMP BRANDON A Weekend Grief Day Camp for Teens
Mary Washington Healthcare

Camper's Name _____

Dear Parent/Guardian,

Thank you for your interest in Camp Brandon. Camp Brandon is a weekend bereavement *day* camp for teens, ages 13 to 18 years, who are grieving the death of a loved one. Camp Brandon is a fun weekend filled with activities focused on helping your child find healthy and positive ways to deal with their loss. It is offered to teenagers residing in Fredericksburg, Stafford, Spotsylvania, King George, and Caroline County at **no charge**. All meals and activities are provided.

CAMP BRANDON Activities Include:

- meditation
- art therapy
- remembrance activities
- group sharing
- games
- music therapy
- crafts
- outdoor activities
- corn hole tournament

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 Brandon will be held:
Saturday, September 28, 11:00 a.m. - 7:00 p.m. and
Sunday, September 29, 10:00 a.m. – 5:30 p.m.
The Virginia Outdoor Center
3219 Fall Hill Avenue, Fredericksburg, VA 22407

Parents/Guardians are responsible for dropping off and picking up their child both days at the time stated above and will need to sign them in and out.

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 grief support programming. Please complete all forms and return the entire packet to the address below as soon as possible to:

Mary Washington Healthcare - Grief Support Services
Attn: Camp Brandon
2103 Washington Avenue
Fredericksburg, VA 22401
Phone: 540-741-1874
Email: griefsupport@mwhc.com

Applications are due no later than August 30, 2019

Mary Washington Healthcare
Grief Support Services

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Application Check List

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

- ✓ Camper Application (pgs. 3-7)
- ✓ Releases (pg. 8)
- ✓ Authorization to Administer Prescribed Medication Form
  ****Complete only if your child must take medication during the day / hours of Camp Brandon. (pgs. 9-10)****
- ✓ Pre-Survey (pg. 11)
- ✓ Consent to Photograph/Interview Release Form (pg. 12)
  The signature on this form MUST be witnessed so please make sure you have someone nearby to sign that they witnessed you sign.

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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 Age_____
Race_____ Date of Birth____/____/____ Phone #_____
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_____

Child's School _____ Current Grade_____

Other Languages Child Speaks_____

Camper's T-Shirt Size: **Adult** ☐ M ☐ L ☐ XL ☐ XXL ☐ XXXL

Child's Height_____ Child's Weight_____

Mary Washington Healthcare
Grief Support Services

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Physician's Name _____ Phone #_____

Medical Insurance Information (Name and ID number) _____

_____

Is the camper restricted from participating in physical activities? ☐ Yes ☐ No
Does the camper have any food restrictions/allergies? ☐ Yes ☐ No
Please list:_____

How did you hear about Camp Brandon?_____

_____

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:

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 ☐ Hospice ☐ Other _____

Cause of death: ☐ Illness ☐ Accident ☐ Homicide ☐ Suicide ☐ 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

CAMP BRANDON | A Weekend Grief Day Camp for Teens
Mary Washington Healthcare

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	☐	☐	☐	☐
Belief that death is a punishment	☐	☐	☐	☐
Hostile behavior towards others – yelling, biting, hitting, swearing	☐	☐	☐	☐
Lack of concentration or memory	☐	☐	☐	☐
Sleep difficulties – sleep walking, disturbing dreams, bed wetting, inability to sleep	☐	☐	☐	☐
Self inflicted injuries or accidents	☐	☐	☐	☐
Alcohol or drug use	☐	☐	☐	☐
Lack of interest in day-to-day activities	☐	☐	☐	☐
Expressing thoughts of loneliness, isolation, suicide, etc.	☐	☐	☐	☐
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._____

_____

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

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

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5. INFORMATION ABOUT YOUR CHILD'S HEALTH

Health History (check those that apply)

- ☐ Attention Deficit Disorder
- ☐ Asthma
- ☐ Appetite (over or under eating)
- ☐ Autism
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Headaches, Stomachaches, Backaches, etc.
- ☐ Hearing Impairment
- ☐ Hepatitis
- ☐ Nightmares
- ☐ Wears Contact Lenses/Glasses
- ☐ Attention Deficit Hyperactive Disorder
- ☐ **Allergies (food, animals, bee stings, medications, etc.)**
- ☐ Constipation/Diarrhea
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Fainting
- ☐ Heart Disease
- ☐ Menstrual Cramps
- ☐ Nosebleeds
- ☐ Special Dietary Needs (Please indicate below).

Others (specify). Please include additional information on checked items. Please list any specific food insensitivities. If your child has a restrictive diet, you will need to provide food and snacks for the weekend. We will have vegetarian options available.

_____

_____

_____

_____

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Is your child currently under a physician's care for a medical condition? ☐ Yes ☐ No

Please explain condition_____

_____

Has your child had a physical/medical exam since the death or during the current year? ☐ Yes ☐ No

We require full disclosure of medical and behavior information to best care for your child during camp. Inaccurate information may result in your having to remove your child from camp.

To the best of my knowledge, the above information is correct and accurate. I understand that if my child's behavior is not manageable at Camp Brandon, I will be contacted to retrieve my child.

_____

Signature of Parent/Guardian Date

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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 Brandon activities, except as noted. If she/he appears to be ill, I will not send her/ him to Camp Brandon. I hereby grant permission to Camp Brandon 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 Healthcare Hospice Support Care Board of Directors, 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 Brandon. Camp Brandon 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 Brandon, 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 Brandon officials will notify me of this decision. I have provided the Camp Brandon officials with a number at which I can be reached and authorize the Camp Brandon officials to contact the physician named below if needed.

Name of Doctor Phone #

Name of Parent/Guardian (Print) Phone #

Signature of Parent/Guardian Date

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AUTHORIZATION TO ADMINISTER PRESCRIBED MEDICATION

COMPLETE ONLY IF CHILD MUST TAKE MEDICATION DURING CAMP BRANDON 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 Brandon 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 Healthcare
Grief Support Services

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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's/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.

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Camper Pre-Survey

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

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? ☐ ☐ ☐
2. Is your child able to express his/her thoughts/feelings about their loss? ☐ ☐ ☐
3. Is your child coping with their loss in a healthy way? ☐ ☐ ☐

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

_____

_____

_____

CAMP BRANDON A Weekend Grief Day Camp for Teens
Mary Washington Healthcare

Camper's Name _____

Mary Washington Healthcare

Consent to Photograph/ Interview and Release of Information

I,_____, consent to having photographs taken of me and/or an interview conducted concerning Camp Brandon activities/events.

Upon occasion, videotaping, and/or photography may occur during camp activities. This material may be used for future publicity for Grief Support Services. Personal comments and interviews may also be published by local media. Without prior approval, I agree to myself/my child being interviewed and having my/his/ her comments and/ or picture used for such purposes.

I hereby release Mary Washington Healthcare, its subsidiaries, and its personnel, from any and all liability which may or could arise from the taking or the use of these photographs/interview, and grant release of general information by a MWHC spokesperson.

_____ _____
Guardian/Participant name printed Guardian/Participant signature

_____/_____/_____ _____
Date Time

*Note: If the participant is a minor (under the age of 18), a legal guardian must give consent on the minor's behalf.

_____ _____
Witness name printed Witness signature

_____/_____/_____ _____
Date Time