Camper's Name ________________________

Mary Washington Healthcare

Grief Support Services

Dear Parent/Guardian,

Thank you for your interest in Camp Rainbow. Camp Rainbow is a weekend bereavement *day* camp for children ages 5 to 12 years who are grieving the death of a loved one. Camp Rainbow 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 children residing in Fredericksburg, Stafford, Spotsylvania, King George, and Caroline County at **no charge**. All meals and activities are provided.

Camp Rainbow Activities Include:

- meditation
- art therapy
- remembrance activities
- group sharing
- games
- music therapy
- crafts
- journaling
- 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 **Saturday, April 6 and Sunday, April 7 from 9:00 a.m. – 4:00 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 both days 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 address below as soon as possible.

Mary Washington Healthcare - Grief Support Services
Attn: Camp Rainbow
2103 Washington Avenue
Fredericksburg, VA 22401
Phone: 540.741.1874

Email: griefsupport@mwhc.com

Applications are due no later than March 8, 2019

Camper's Name ______________________

Mary Washington Healthcare

Grief Support Services

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 hours of Camp Rainbow. (pgs. 9-10)

✓ Pre-Survey (pg. 11)

✓ Consent to Photograph/Interview Release Form (pg. 12)
YOU MUST HAVE A WITNESS SIGN THIS FORM.

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: **Youth** ❑ M ❑ L ❑ XL **Adult** ❑ M ❑ L ❑ XL
Child's Height________________________________ Child's Weight______________________________

Camper's Name ______________________

Mary Washington Healthcare

Grief Support Services

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 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:

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 Yes, please provide additional details in Section 3

Camper's Name ______________________

Grief Support Services

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.

____

____

____

Camper's Name ________________________

Mary Washington Healthcare

Grief Support Services

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

- ❑ Talking with a friend
- ❑ Talking with family
- ❑ Writing or drawing
- ❑ Talking or writing to the deceased
- ❑ Physical activity/sports
- ❑ 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 ________________________

Mary Washington Healthcare

Grief Support Services

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 in order 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 Rainbow, I will be contacted to retrieve my child.

____ ___________
Signature of Parent/Guardian Date

Mary Washington Healthcare

Grief Support Services

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 she/he appears to be ill, I will not send her/ him 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 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 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

Camper's Name ________________________

Mary Washington Healthcare

Grief Support Services

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

Camper's Name ______________________

Mary Washington Healthcare

Grief Support Services

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.

Camper's Name ________________________

Mary Washington Healthcare

Grief Support Services

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:

____

____

____

Camper's Name ______________________

Mary Washington Healthcare

Grief Support Services

Mary Washington
Healthcare

Consent to Photograph/ Interview and Release of Information

I,_____________________________________, consent to having photographs taken of me and/or interview conducted concerning Camp Rainbow 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 my child being interviewed and having 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 release of general information by a MWHC spokesperson.

__________________________ __________________________________

(Witness) (Participant's signature)

_____/_____/_____ _____________________

(Date) (Time)

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

__________________________ __________________________________

(Witness) (Closest relative or legal guardian)

_____/_____/_____ _____________________

(Date) (Time)

Camper's Name ________________________

Mary Washington Healthcare

Grief Support Services

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 dates for Camp (April 6 and 7, 2019)
- We will process applications as they are received. Space is limited so please return the application(s) as soon as possible, but **no later than March 8, 2019**. 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 Ann Bernardi, LCSW at 540.741.1874 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.
- **Please remember that parent(s)/guardian(s) are required to attend the Camp Rainbow closing ceremonies on April 7 beginning at 3:00 p.m. for a special celebration.**
- **Please send with your child to Camp Rainbow a *copy* of a photo of your child's loved one who died to be used in a remembrance activity.**