Please mail forms by Friday, September 28 to: Rice Hospice, 301 Becker Ave SW, Willmar MN 56201 or fax to: 320-231-4875.

Participant's Name_____ **Date of Birth**_____ **Grade in School**_____
Gender: ☐ **Male** ☐ **Female**

BEREAVEMENT HISTORY

Who was the person who died? (Name) _____

Relationship to your child_____Date of death_____

Cause of death_____

Age of person who died_____Age of child at time of death_____

Where did this person die? Home_____Hospital____Nursing Home____Other_____

Was your child present at time of death? Explain Circumstances_____

_____

Did your child attend the funeral/memorial service?_____

Has your child received any professional support? (psychologist, psychiatrist, pastoral counselor, school counselor, grief counselor) If yes, how long was professional support provided?

_____

Have there been multiple deaths of loved ones experienced by this child? If yes, please explain.

_____

Are there any other changes/stresses in your child's life? (divorce, illness, relocation)

_____

PUBLICITY RELEASE

I authorize **Rice Hospice** staff/volunteers to use my child's name, photograph, and/or story for use in informational and/or publication materials.

Yes_____ No_____

I authorize **Rice Hospice** staff/volunteers to use my name and comments for use in informational and/or publication materials. Yes_____ No_____

_____
Print Name (Parent/Legal Guardian)

_____
Signature (Parent/Legal Guardian)

_____
Date

Participant's Name_____**Age**_____

HEALTH HISTORY

(Check all that apply)

_____Hearing Impairment _____Asthma _____Emotional Problems

_____Special Dietary Needs _____Allergies (Specify, i.e. latex, dog, certain food/snacks, etc.):

_____

Other (Specify)_____

Please explain any area(s) that are checked_____

Are there any activities that your child cannot participate in?

Please explain:_____

Does your child have any disruptive or acting-out behaviors? Please explain:_____

_____

Is your child taking any medication prescribed by a physician? Please explain:_____

_____

Are your child's immunizations up to date? Yes____ No_____ Child's Physician/Clinic_____

The health history provided in this packet is correct so far as I know, and the child herein described has my permission to participate in all prescribed activities except as noted. I give permission to the program staff to share information contained in this document with the volunteer(s) and staff who will be working with my child. In the event I cannot be reached, I authorize the camp to secure a doctor to provide any necessary emergency medical care.

❑ Yes ❑ No

RELEASE OF LIABILITY

Neither Camp G.K. Bear staff/volunteers, other camp participants, Rice Hospital, nor any other group or individual connected with putting on this day shall be held liable for any injury, loss, theft, or damage, either personal or property, of anyone while attending camp.

I have read, understand, and accept these terms for attending Camp G.K. Bear and hereby release anyone involved with this camp from any and all responsibility. ❑ Yes ❑ No

_____ _____

Signature or parent/guardian Date

_____ (_____)_____

Address Daytime Phone

_____ (_____)_____

City State Zip Emergency Phone