

Please mail forms by **Friday, April 19** 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