



# FAMILY GRIEF CAMP

MAY 22, 2010

VERDUN ADVENTURE BOUND, RIXEYVILLE

## PRE-REGISTRATION APPLICATION

Each Family Grief Camp participant must be pre-registered by **Wednesday, May 19, 2010**. Please do not assume you are registered until you have received confirmation. A separate application should be completed for each child attending the Family Grief Camp. If two adults who reside together will accompany one or more children (i.e., parents), then include both names in the "Adult Information" section.

We reserve the right to cancel the camp due to insufficient number of registrants. In this event, notifications will be made by phone. Please note that all information submitted on this application is maintained as confidential.

### CHILD INFORMATION

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

City: \_\_\_\_\_, VA Zip: \_\_\_\_\_

Age on 5/22/10: \_\_\_\_\_

Nickname: \_\_\_\_\_

Sex: \_\_\_\_\_

Is the child currently receiving medical care?  Yes\*  No

If yes, please explain: \_\_\_\_\_

\* If the child is on medication it is the sole responsibility of his or her parent or guardian to administer it

Is the child currently receiving professional counseling or psychiatric care?  Yes  No

If yes, what is the name of the child's counselor/therapist? \_\_\_\_\_

*The counselor/therapist will not be contacted without parent or guardian permission*

Does the child have an effective support network of family, loved ones and/or friends?  Yes  No

Will the child have a sibling or siblings attending the camp?  Yes  No

**ADULT INFORMATION**

Adult's Last Name: \_\_\_\_\_ First Name(s): \_\_\_\_\_ MI: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

City: \_\_\_\_\_, VA Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Is the adult currently receiving medical care?  Yes  No

If yes, please explain: \_\_\_\_\_

Is the adult currently receiving professional counseling or psychiatric care?  Yes  No

If yes, what is the name of the adult's counselor/therapist? \_\_\_\_\_

*The counselor/therapist will not be contacted without your permission*

What is your expectation regarding the Family Grief Camp? \_\_\_\_\_

How did you hear about the Family Grief Camp? \_\_\_\_\_

**INFORMATION ABOUT THE PERSON WHO DIED**

Name of Deceased: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Date of Death: \_\_\_\_\_ Age at Death: \_\_\_\_\_ Cause of Death: \_\_\_\_\_

Please list any other significant loss(es) the child has experienced: \_\_\_\_\_

**Please attach a wallet size photograph of the person who died**

**EMERGENCY CONTACT**

Person, **not attending the Family Grief Camp**, to contact in case of emergency involving either the child or adult –

Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**SIGNATURE**

Name of person completing this form: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please mail completed forms to: Craig Wilt, Hospice of the Rapidan, P. O. Box 1715, Culpeper, VA 22701**