



Dear Parent/Guardian,

Thank you for your interest in Camp Chimaqua on August 18-20, 2006, at Camp Donegal. The camp application and health forms available on our website are designed to give you an opportunity to share information needed to make certain your child's camp experience is beneficial and rewarding. Please answer all questions that apply and bring the packet with you when you and your child(ren) meet with a PATHways Center grief counselor. The information you provide will help us plan an enjoyable camping experience for your child. If you have more than one child attending, a separate packet must be completed for each child.

The Sertoma Club for Hospice of Lancaster County covers the majority of the costs for this program, however we do request a \$25 registration fee per person. Checks should be made payable to Hospice of Lancaster County and included with the registration. There will be no additional charge for attending the weekend. Financial assistance for the registration fee is available if needed. For more information, please call the PATHways Center staff at 391-2413. In mid-May, registrations will be confirmed and additional information will be sent regarding what your child will need to bring to camp.

Space is limited and reservations are made on a first-come, first-serve basis. All families interested in Camp Chimaqua for their child(ren) must meet with a PATHways Center counselor before they can be fully registered. If you have questions about the camp or any of the application forms, please call the PATHways Center for Grief & Loss at 391-2413.

We look forward to hearing from you!

Michele Fry

Michele Fry
Bereavement Counselor



Serving Lancaster County Since 1980

685 Good Drive, P.O. Box 4125 • Lancaster, PA 17604-4125
(717) 391-2413 • www.hospiceoflanaster.org • Email: info@hospiceoflanaster.com

HEALTH HISTORY (Check those that apply)

- Allergies (food, animals, etc)
- Constipation/diarrhea
- Diabetes
- Emotional problems
- Fainting
- Heart disease
- Menstrual cramps
- Nose bleeds
- Special dietary needs
- Wears glasses
- Asthma
- Convulsions/seizures
- Ear infections
- Epilepsy
- Hearing impairment
- Kidney disease
- Motion sickness
- Sickle cell anemia
- Wears contact lenses
- Other (specify)

Please explain any “yes” answers to the questions. Indicate any useful information in relation to any of these health conditions. Also indicate any activities to be encouraged or restricted.

Immunizations

Series Completed

- DTP _____
- Measles _____
- Mumps _____
- Oral Polio _____
- Rubella _____
- Tetanus Shot _____

Tuberculin Test:

- Type: _____
- Year Last given: _____
- Result: _____

I know of no health reason(s), other than the information given on this form, why my child should not participate in any of the Camp Chimaqua activities. I also give permission for the camp nurse to administer: Tylenol (up to two regular tablets every four hours, as needed), Ibuprofen (200 – 400 mg every four hours, as needed) or Robitussin DM (1-2 tsp. every four hours, as needed) for complaint of mild aches and cough.

Signature of Parent/Guardian Date



**CAMP CHIMAQUA
NURSE'S MEDICATION ORDER FORM**

CHILD'S NAME: _____

The following medications must be given during the Camp:

MEDICATION	DOSAGE	TIME(S) TO BE GIVEN
1.		
2.		
3.		
4.		

Method of administration (to be taken with water, mild, food, etc): _____

List any reasons for not giving medication at the prescribed time (vomiting, fever, drowsiness, convulsions): _____

Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION

I/We authorize and request Camp Chimaqua personnel to administer the medication(s) prescribed by our physician, and in doing so, relieve the camp, its agents, employees or representatives of any responsibility for ill effects which may result from the administration of said prescribed medication(s). I also give permission for the camp nurse to administer: Tylenol (up to two regular tablets every four hours, as needed), Ibuprofen (200-400 mg every four hours, as needed) or Robitussin DM (1-2 tsp. every four hours, as needed) for complaint of mild aches and cough.

Parent/Guardian Signature: _____ Date: _____



CAMP CHIMAQUA LOSS HISTORY

Please take a few minutes to provide us with some background information about your child's loss(es) and their impact on your child. We very carefully consider the information you provide us, along with personality in matching your child with an adult buddy for the weekend. The more details you provide us with, the more successful we can be in tailoring the weekend to specifically meet your child's needs.

1. What is the relationship of your child to the person who died? _____

2. Please indicate the date and cause of death. _____

3. Was Hospice of Lancaster County involved? _____ yes _____ no

4. Was your child aware that death was going to occur beforehand or did this come as a surprise? (Please explain) _____

5. What behavior(s) does your child exhibit that indicate he/she is still grieving? _____

6. Does your child have difficulty sleeping or cry at night? If so, how have you handled this? _____

7. Have there been other deaths in the past that your child has had to cope with? If so, who died and when did this occur? _____

8. Are there any other changes/stresses that have occurred in recent months for your child? (i.e. divorce, illness, moves, changes in friendships, loss of pets, fears) _____



CAMP CHIMAQUA CAMPER INFORMATION

In order to help us get to know your son/daughter better, please have him/her complete the following page. The more information we have, the better we can ensure a positive camping experience.

Name of Camper: _____

What are your favorite things to do?

Outside:

Inside:

Have you ever been away at an overnight camp? Yes ___ No ___

How well can you swim?



Can you hold your breath under water?

Yes ___

No ___



Have you had swimming lessons?

Yes ___

No ___



Can you float?

Yes ___

No ___



Can you swim in water over your head?

Yes ___

No ___

Are you worried about anything that you would like us to know about?

What is your favorite meal?

Is there anything you should not eat?

☺ **THANK YOU FOR HELPING US GET TO KNOW YOU!!!** ☺



CAMP CHIMAQUA PARENT/LEGAL GUARDIAN PERMISSION STATEMENT

Hospice of Lancaster County considers the information you provide regarding your child to be confidential. It will only be made available, to the extent necessary, to appropriate camp staff, volunteers, and counselors who will be working with your child.

I understand and agree that if my child appears ill prior to attending camp, I will not send my child to camp.

I understand and agree that Hospice of Lancaster County/Camp Chimaqua may photograph my child in the camp setting and utilize camp photographs for related presentations or publications for educational purposes.

Permission is granted for my child to participate in all camp activities (which are more fully described in camp materials) except as limited or excluded in the Health History Form. I am not aware of any other health reason(s) (other than those documented) that would preclude my child from participating in camp activities.

I confirm that all information provided is, to the best of my knowledge, accurate and complete.

I understand that, in the event of a medical emergency I will be immediately contacted. Hospice of Lancaster County on-site medical staff (registered nurse, CPR certified staff and/or physician) will initiate immediate medical, and if necessary, life sustaining measures and will contact, if needed, emergency medical personnel for assistance.

I further understand that my preferred physician/medical facility will be contacted and utilized whenever possible. If I am unable to be reached and medical circumstances require immediate transport for care, this will be initiated and emergency medical personnel will provide for the immediate needs of my child and determine the transport location.

Preferred Physician: _____ Hospital: _____
(name & phone #)

Medical Insurance: _____ Phone Number: _____

Policy Holder's Name: _____ Group Number: _____

Employer: _____

I hereby release and discharge Hospice of Lancaster County, its employees or volunteers from any legal responsibility and/or liability for any personal injuries or illnesses, either physical or emotional; or injury to property, real or personal, whether that injury is due to negligence or any other fault, which may occur while my child attends Camp Chimaqua. I have read the information on the PATHways Center for Grief & Loss. I have received Hospice of Lancaster County's *Notice of Privacy Practices*. I understand the Camp Chimaqua program provided by the PATHways Center for Grief & Loss, have had the opportunity to ask questions and have received acceptable and understandable answers. I choose to avail myself/my children of this service voluntarily and with full knowledge of its benefits and limitations.

Child's Name (1) (please print)

Child's Name (2) if applicable (please print)

Signature: Parent(s)/Guardian(s)

Date



NOTE: If your child brings medication to camp, it **must** be in the original labeled container. Instructions must be printed on the label or on a separate prescription that is signed by the physician.

If your child is routinely on medication, please list the medication(s) you anticipate being sent to camp:

Child's Name: _____

You will meet with the camp nurse when your child first arrives at camp.