



**STATE OF THE HEART HOSPICE  
CAMP BEARable APPLICATION**

Dear Parent or Guardian,

Please complete the following application and medical record form with the understanding that your child is not accepted into the Camp BEARable program until we receive this completed form at the State of the Heart Hospice office.

As the parent or guardian of \_\_\_\_\_, I hereby give my permission for my child to participate in the supervised camping program of State of the Heart Hospice. I release the Camp staff, management, said Camp, and State of the Heart Hospice from liability, except as covered by insurance, for any injury or illness which may be sustained by him/her while enrolled and present at the Camp. In case of a medical emergency, my child will be transported to Mercer Health. After every reasonable effort has been made to contact parent, guardian, family physician or one of the alternative contacts named below, I hereby give my permission to the physician selected by the Camp Director to hospitalize and secure appropriate and proper medical treatment for my child, named above.

\_\_\_\_\_  
Print Parent or Guardian Name

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address, City, State & Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address

**PERSONAL/MEDICAL RECORD**

Name of Camper \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

School attending \_\_\_\_\_ Grade \_\_\_\_\_

Please list your child's religious affiliation, if any. (Optional) \_\_\_\_\_

Has your child ever spent the night away from home?      Yes      No

Does your child have any sleep problems (e.g., sleepwalking, bedwetting, nightmares)?

\_\_\_\_\_

Child's T-shirt size:

Children: \_\_\_\_\_ S (6-8) \_\_\_\_\_ M (10-12) \_\_\_\_\_ L (14-16) Adult: \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ L \_\_\_\_\_ XL

Telephone number, pager/cell phone number and/or address of where you can be reached while your child is at Camp: \_\_\_\_\_

Names of two alternative contacts that you authorize to act on your behalf in case you cannot be reached in an emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Name of child's dentist \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance ID# \_\_\_\_\_ Give date of last Tetanus \_\_\_\_\_

Does this child have any known physical, mental or social difficulties for which special consideration may be given at Camp?

\_\_\_\_\_

\_\_\_\_\_

Health History (check all that apply)

\_\_\_\_\_ Attention Deficit Disorder (ADD) \_\_\_\_\_ ADHD \_\_\_\_\_ Emotional Problems

\_\_\_\_\_ Acquired Immune Deficiency Syndrome (AIDS) \_\_\_\_\_ Asthma

\_\_\_\_\_ Allergies (food, animals, bee stings) \_\_\_\_\_ Convulsions/Seizures

\_\_\_\_\_ Constipation/Diarrhea \_\_\_\_\_ Ear Infections \_\_\_\_\_ Motion Sickness

\_\_\_\_\_ Diabetes \_\_\_\_\_ Fears \_\_\_\_\_ Fainting \_\_\_\_\_ Heart Disease

\_\_\_\_\_ Hearing Impairment \_\_\_\_\_ Hepatitis \_\_\_\_\_ HIV \_\_\_\_\_ Kidney Disease

\_\_\_\_\_ Menstrual Cramps \_\_\_\_\_ Sickle Cell Anemia \_\_\_\_\_ Developmentally Delayed

\_\_\_\_\_ Nightmares \_\_\_\_\_ Nosebleeds \_\_\_\_\_ Phobias \_\_\_\_\_ Special Dietary Needs

\_\_\_\_\_ Wears Glasses \_\_\_\_\_ Wears Contact Lenses

\_\_\_\_\_ Other (please explain) \_\_\_\_\_

**As a courtesy to other campers, please do not send your child to camp if he/she has a fever or other communicable disease (lice, poison ivy, scabies, ringworm, etc.) that can be transmitted to others or is of extreme discomfort to your child.**

Please explain any information we need to know to care safely for your child: \_\_\_\_\_

Does your child have any special dietary needs? Please indicate what they are: \_\_\_\_\_

**BEREAVEMENT HISTORY**

Name of loved one who died: \_\_\_\_\_

Date of death: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Where did the person die? Home \_\_\_\_\_ Hospital \_\_\_\_\_ Nursing Home \_\_\_\_\_

Explain circumstances: \_\_\_\_\_

Did the child attend funeral/memorial service? Yes \_\_\_\_\_ No \_\_\_\_\_

Other changes/stresses in the child's life?

- a. Divorce or separation \_\_\_\_\_
- b. Moving \_\_\_\_\_
- c. Friends moving \_\_\_\_\_
- d. Other deaths? \_\_\_\_\_ If yes, who? \_\_\_\_\_
- e. Pet death? \_\_\_\_\_
- f. Parent changing job or loss of job \_\_\_\_\_
- g. Other trauma \_\_\_\_\_

How did the child handle these changes? \_\_\_\_\_

Please explain how your child indicates that he/she is grieving: \_\_\_\_\_

Has the child received professional support (psychiatrist, psychologist, pastoral or school counselor)? Explain: \_\_\_\_\_

Please identify present behaviors at home or school:

Less interactions _____	Bed wetting _____
Changes in sleep _____	Emotional outbursts _____
Changes in appetite _____	Nightmares _____
Dropping grades _____	Fear of dark _____
Inability to concentrate _____	Cries frequently _____
Excessive talk about death & loss _____	Clinging behavior _____

### **PARENT OR GUARDIAN STATEMENT**

I give permission to State of the Heart Hospice to have pictures taken at Camp BEARable which may be used for publication.

I believe all of the answers to the questions above are true & that my child is in good health and is able to participate in all the normal activities of Camp BEARable.

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

Please return the completed application to:

State of the Heart Hospice  
1350 N. Broadway  
Greenville, Ohio 45331

Questions may be directed to Marlene Black, Bereavement Specialist and Camp Director, at [mblack@stateoftheheartcare.org](mailto:mblack@stateoftheheartcare.org), 937.548.2999, or 800.417.7535.