Friends of Oswego County Hospice, Inc.

Jim Arnold

Camp Rainbow of Hope
Camper Application Form

Child's Name: ____ (nickname) ______________

School Grade as of Fall 2011____Age: ____Birth Date: ____/____/__

Sex: Female: ____Male: ____

School Attended: ____

Parent/Legal Guardian: ____

Relationship: ____

Street Address: ____

City: __________________________State: ____Zip: ________________

Home Phone: (____)____________Work Phone: (____)_____________

Cell Phone: __________________e-mail Address: ________________

Name of Child's Physician: _______________________Phone: (____)_________

Please list any food allergies, dietary restrictions (physician recommended/religious, etc.):

Please list your child's religious affiliation (if any): ___________________________

Has your child ever spent the night away from home? ____Yes____No

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

Please list any additional information (problems with eating, getting along with friends/peers or family members, school attendance, physical limitations, etc.):

Child's T-shirt Size:
Children ____S (6-8)____M (10-12)____L (14-16)
Adult ____S____M____L____XL

Please list any sports/interests/hobbies that your child has:

Camp Rainbow of Hope
Bereavement History

Please include as many details as possible when answering the following questions.
Attach extra pages if necessary.

1. Who was the person or persons who died (name): ___________________________________

2. How was the person related to the child? __________________________________

3. What was the cause of death? ____

4. When did the death occur (date)? ____

5. Age of your child when the death occurred:__________________________________

6. Where did this person die? Home____Hospital____ Explain:

7. Was the child present at the time of death? Explain circumstances.

8. Did the child attend the funeral/memorial service? If yes, what was your child's reaction to/or comments about the service?

9. Has your child received any professional support (i.e. school counselor, peer support group, psychologist, psychiatrist, pastoral counselor)?

   ____Yes ____No (if no, skip to #10)

   If yes, is support currently being provided?
   ____Yes____No

   If counseling is no longer in progress, how long was the period of support provided?

10. Please explain how your child indicates that he/she is grieving.

11. Have there been multiple deaths of loved ones experienced by this child? If yes, please describe the nature of death and the child's relationship to the other person who died.

12. Have there been any other changes/stresses in your child's life (i.e. divorce, remarriage, relocation, illness)?

Camp Rainbow of Hope Health History Form

Camper's Name: ____
(Last) (First)

Home Address: ____

Date of Birth: _______________Age: ___________ Sex: ___________

Child's Height: _______________Child's Weight: _____________________

Parent/Guardian ____
(Last) (First)

Parent/Guardians Phone (Day): __________(Evening): _________(Cell Phone):_________

Emergency Contact: __________________________________ Relationship: _______________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ________________

Alternate Emergency Contact: __________________________________ Relationship: _______________

Home Phone: ______________ Work Phone: __________ Cell Phone: ________________

Information about your child's health history is to insure his/her safe stay at Camp. It will not have any bearing on whether your child is chosen to attend. Child will not be allowed to come to camp unless he/she has all vaccinations and/or booster. **Give date (month and year) of last vaccination for each listed:**

Polio _____ Diphtheria _____Rubella_____Mumps_____Tetanus_____Measles_____

Health History (check those that apply):

____Attention Deficit Disorder (ADD)
____Constipation/Diarrhea
____Diabetes
____Fainting
____Hearing Impairment
____Menstrual Cramps
____Nightmares
____Hay Fever
____Wears Contact Lenses/glasses
____Developmentally Delayed
____Asthma
____Convulsions/Seizures
____Emotional Problems
____Severe Reaction to poison ivy
____ Heart Disease
____Hepatitis
____Kidney Disease
____Frequent ear infections
____Bleeding/Clotting Disorder
____Other (please explain)

Severe reaction to insect or bee stings? Yes or No (circle One) If yes, is medication provided?
____

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

Medications: ____
____

Child's Health Care Carrier: ____________________Effective Date: __________

Plan Number: _________________________Group Number: ___________

Food Allergies: ____

Drug Allergies: ____

Other Significant Allergies: ____

Are there any activities your child may not be able to participate in while at camp?
____Yes ____No (If Yes, please explain):

Physician's Name: _____________________________Phone Number: ___________

The Health History is correct to my knowledge. The person herein described has permission to engage in all prescribed camp activities except as noted. I give my permission, in the case of any emergency that requires hospital admittance or treatment, for the Camp Rainbow of Hope staff and/or emergency medical staff to care for my child and receive discharge information from the hospital until I can be contacted. Also, I give my permission for my child's picture to be taken and used for publicity purposes only.

____Date: ___________
Signature of Parent/Guardian

Please Return this Application to:

Debbie Bishop, Executive Director
Friends of Oswego County Hospice
P.O. Box 102
Oswego, NY 13126

Or email to:
oswegohospice@verizon.net

Applications Must Be Received By July 1, 2011