Wings to Soar Camp

CHILD/TEEN REGISTRATION

***** Pre-registration for Wings to Soar Camp is necessary*****
For each child who will be attending, please send this completed registration form with medical information to:
Shea.Collins@CarolinasHealthCare.org or mail it to:
Hospice and Palliative Care of Cabarrus County - (Attn: Wings to Soar) - 5003 Hospice Ln, Kannapolis, NC 28081
Hospice of Union County - (Attn: Wings to Soar) - 700 W Roosevelt Blvd, Monroe, NC 28110

CAMPER INFORMATION

Camper's Name: ____
Last First MI

Prefers to be called _______________________________ Date of Birth: ______________________

Age ______________ *Choose One:* Adult T-shirt size_____________________
Child T-shirt size______________________

School: ____ Grade: ______________________________

Referred by: ☐ Self ☐ Hospice Flyer ☐ Newspaper ☐ School Counselor ☐ Hospice Staff

☐ Other ____

PARENT INFORMATION

Parent/Guardian: ____

Address: ____

Home Phone: ________________________ Work Phone: ____

Cell: ________________________________ E-Mail: ____

Do both parents live in the home? ☐ Yes ☐ No

If not, please provide the following contact information:

Parent/Guardian Name: ____

Mailing Address: ____

Phone Numbers: Home: ___________________________ Work: ______________________________

Cell: ___________________________ E-Mail: _____________________________

** Both parents/guardians are recommended to participate in the adult session while the child is at camp.*

WINGS TO SOAR

Carolinas HealthCare System

Name of deceased person: ____

Relationship of deceased to child: ____

Was deceased a Hospice and Palliative Care of Cabarrus County patient? ☐ Yes ☐ No

Was deceased a Hospice of Union County patient? ☐ Yes ☐ No

Did the child live with the deceased? ☐ Yes ☐ No

Date of death: _____________________________ Age at death: ____________________________

Type of Death: ( ) Accident ( ) Long term illness ( ) Short term illness ( ) Traumatic (Murder/Suicide)

Please elaborate: ____

____

____

Was the child present with the deceased at the time of death: ☐ Yes ☐ No

Other significant losses in the past 2 years: ____

Since the Death, what changes have you seen? (Check items)

( ) School Problems
( ) Friends (fighting/withdrawal)
( ) Expresses desire to die or kill self
( ) Emotional Struggles (crying, confusion, guilt, bedwetting)
( ) Physical Symptoms (sleeping more/less, appetite changes, physical complaints)
( ) Nightmares
( ) Increase in fears
( ) none

List other current stresses for the child (ex. Divorce, separation, move, etc.): _____________________

____

Has your child/teen been in any support groups or counseling? ☐ **Yes** ☐ **No** *If yes, please explain:*

____

____

Interests and Special Abilities:

____

Additional Information:

____

What are your expectations of Wings to Soar Camp?_______________________________________

____

I grant permission for photographs/videos/tape recordings, written evaluation comments, or interviews with my child to be used for educational purposes and/or to promote future camps and release Camp Wing2Soar, Carolinas Palliative Care and Hospice Network, Inc. d/b/a Hospice & Palliative Care of Cabarrus County and its parent, predecessors, successors, subsidiaries, assigns, affiliates, related entities, divisions, directors, officers, commissioners, members, employees, volunteers, agents, attorneys, representatives, heirs and assigns from and against any and all claims, damages, liability, costs, or demands, arising from or relating to such use.

☐ **Yes** ☐ **No**

____

Parent/Guardian Signature Date

____

Parent/Guardian Signature Date

Children's Medical Information – Wings to Soar Camp
Please complete both sides of this form.
Health History Forms must be on record for all children who participate in the camp

Name: ____
Last First MI

DOB: ______________ Sex: ________ Age: ________________

Prefers to be called: ______________________________________

Parent or Guardian: ______________________________________

Home Address: ____
Street and Number City State Zip Code

Phone: ______________________ Cell Phone: ______________________

E-mail: ______________________ Work Phone: ______________________

MEDICAL INFORMATION

List any physical or mental concerns your child may have: ______________________

____

Are there any activities that should be restricted? ______________________

____

List any medications that are taken. (If necessary, medications will be dispensed by the Camp Nurse).

Medication Taken	Dose	Time Taken
________________	________	________
________________	________	________

List any allergies that we should know about (ex. Hay Fever, Insect Stings, Penicillin, Asthma etc.):
____

List any food allergies or diet restrictions:
____

Date of last immunizations: ________________ Tetanus: ________________

Health Insurance: ____

Name of Insured: ____

Policy Number: ____

IN CASE OF EMERGENCY, THE CAMP SHOULD NOTIFY

If the parent/guardian is not available in event of an emergency, please notify:

Name: ____ Phone: ____________________________

Relationship to Camper: ____

Secondary responsible party to notify in case we cannot reach the person listed above:

Name: ____ Phone: ____________________________

Relationship to Camper: ____

Primary Physician: ____________________________________ Phone: ___________________________

Name of Practice: ____

Dentist: ____ Phone: ___________________________

IMPORTANT --THIS SECTION MUST BE COMPLETED FOR ATTENDANCE!!

This health history is correct as far as I know, and the child herein described has my permission to engage in all prescribed camp activities except those expressly noted herein.

AUTHORIZATION FOR TREATMENT:

I hereby give permission to the camp medical personnel to release medical history information, to contact the primary care physician and/or dentist, and/or to provide or arrange related transportation for my child named herein in case of emergency to the nearest medical facility. In the event, I cannot be reached in an emergency, I hereby give permission to the camp medical personnel to secure and administer treatment, including hospitalization for my child. I understand that no accident or medical insurance is provided and agree that I will be financially responsible for any medical treatment received by my child.

Signature of Parent or Guardian ____

Date ____

I hereby release Wings to Soar Camp, Carolinas Palliative Care and Hospice Network, Inc. d/b/a Hospice of Union County, Hospice and Palliative Care of Cabarrus County and its parent, predecessors, successors, subsidiaries, assigns, affiliates, related entities, divisions, directors, officers, commissioners, members, employees, volunteers, agents, attorneys, representatives, heirs and assigns from and against any and all claims, damages, liability, costs, or demands, arising from or relating to my child's participation in Wings to Soar Camp including, without limitation, any personal injury or property damage that my child may sustain, however caused and whenever realized.

Parent/Guardian Signature ____

Date ____

Informed Consent – Wings to Soar Camp

The mission of **Wings to Soar Camp** is to assist grieving children by providing a safe and compassionate environment for children to share their feelings and emotions, understand their grief and begin the healing process. Although there will be fun, games, and music at the camp, there will also be grief support groups for campers to talk and express their own emotions.

With that in mind, we recognize that most people choose grief support with hopes of feeling better. However, we want you to know not every step forward is bright and sunny. While it is easy to imagine the relief, sweet smiles and pleasant memories, there are also things that may happen when a child begins processing the potentially unpleasant aspects of healthy grieving, such as sadness, anxiety, anger, guilt, or frustration.

As they begin processing the sadness, anger, etc., it is not uncommon for children/adolescents to report feeling worse after grief camps. It is our goal to support them as they sort through these feelings and provide them with emotional and social tools to handle their feelings more effectively with each passing day.

Some of the Reactions to Grief Work to Look for After the Camp

Sleep disturbances	Fatigue	Headaches
Anger	Dreams	Stomachaches
Fear	Preoccupation	Withdrawal
Relief	Confusion	Anxiety
Sadness	Verbal attacks	Crying
Extreme Quietness	Nightmares	

What to Do

Talk with your child. Let them know that you are prepared to listen when they are ready. Don't force the child to talk before he/she is ready. Call the bereavement support team at Hospice and Palliative Care of Cabarrus County (704) 935-9434 or Hospice of Union County (704) 292-2100 with any concerns. We are available to any child or family who attends camp.

I have read the above and understand the goals, benefits, and risks of Wings to Soar Camp and hereby release Wings to Soar Camp, Carolinas Palliative Care and Hospice Network, Inc. d/b/a Hospice of Union County, Hospice and Palliative Care of Cabarrus County and its parent, predecessors, successors, subsidiaries, assigns, affiliates, related entities, divisions, directors, officers, commissioners, members, employees, agents, attorneys, representatives, heirs and assigns from and against any and all claims, damages, liability, costs, or demands, arising from or relating to my child's participation in Wings to Soar Camp including, without limitation, any personal injury or property damage that my child may sustain, however caused and whenever realized.

Parent Signature____________________________________Date__________________________

Witness Signature___________________________________Date__________________________

WINGS TO SOAR

Carolinas HealthCare System