Wings to Soar Camp Application

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@AtriumHealth.org or mail it to:

Hospice & 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

Name: ____
Last First MI

DOB: ____________________ Sex: __________ Age: ________________

Prefers to be called: ____

Parent of Guardian: ____

Home Address: ____

Home Phone: ______________________ Work Phone: ______________________

Email: ______________________ Cell Phone: ______________________

Camper T-shirt Size: Adult / Child (*Circle One*) Small / Medium / Large / XL / XXL (*Circle One*)

School: ____

Grade: ______________________________

PARENT INFORMATION

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

Primary Parent/Guardian Name: ____

Address: ____

Home Phone: ______________________ Work Phone: ______________________

Email: ______________________ Cell Phone: ______________________

Contact information for parent living away from primary home:

Parent/Guardian Name: ____

Address: ____

Home Phone: ______________________ Work Phone: ______________________

Email: ______________________ Cell Phone: ______________________

WINGS TO SOAR

Atrium Health

Wings to Soar Camp
Children's Medical Information

<u>**Please complete both sides of this form.**</u>

NOTE: This form is given to and reviewed by our camp nurse, therefore must be filled out in its entirety prior to acceptance of camper application.

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:

____

Is camper up to date with all immunizations? ______________________________

Health Insurance: ______________________________

Name of Insured: ______________________________

Policy Number: ______________________________

WINGS TO SOAR

Atrium Health

IN CASE OF EMERGENCY, THE CAMP SHOULD NOTIFY

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

Name: ______________________________ Home Phone: ____________________

Cell Phone: ____________________

Relationship to Camper: ______________________________

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

Name: ______________________________ Home Phone: ____________________

Cell 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 ______________________________

LIABILITY RELEASE:

I hereby release Wings to Soar Camp, Carolinas Palliative Care and Hospice Network, Inc. d/b/a Hospice of Union County, 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 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.

Signature of Parent or Guardian ______________________________

Date ______________________________

WINGS TO SOAR

Atrium Health

CAMPER LOSS

Name of deceased person: ____

Relationship of deceased to child: ____

Was deceased a Hospice & 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: ______________________ Deceased age at death: ____________

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

Please elaborate: ____

____

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____

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

Other significant losses/changes in the past 2 years: ______________________________

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WINGS TO SOAR

Atrium Health