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

Camper's Name:

_____
Last First MI

Prefers to be called: _____ Camper T-shirt Size - Circle one: Adult / Child

Date of Birth: _____ Age: _____ Circle one: Small / Medium / Large / XL / XXL

School: _____

Grade: _____ Circle one: Male / Female

PARENT INFORMATION

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

Primary Parent/Guardian:_____

Address: _____

Home Phone: _____ Work Phone: _____

Cell: _____ Email: _____

Contact information for parent living away from primary home:

Parent/Guardian Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell: _____ Email: _____

Wings to Soar Camp
Children's Medical Information

Please complete both sides of this form.

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.

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: _____

Email: _____ 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:

_____

Is camper up to date with all immunizations? _____ Date of last 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: _____ 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 _____

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: _____ 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?_____

_____

_____

Participating in Atrium Health Communications and Marketing

Atrium Health is committed to improving health, elevating hope, and advancing healing for everyone. Sharing your patient story can help us achieve that goal. Out of respect for your privacy and other rights, we would like your permission to use your health information and your images. Please review the below forms, and sign and date each of them as appropriate. If you have questions or concerns, please call our Corporate Communications, Marketing & Outreach department at 704-631-0930.

1. **For Patients Only:** If you are patient or the patient's parent/guardian/personal representative and you are giving us permission to use and disclose the patient's information, please sign and date the ***Authorization to Use and Disclose Information for Communication and Marketing***.

2. **For All Relevant Persons:** If you are giving us permission to use your image, likeness, and other forms that are unique to you in our marketing and communications materials (even if you are not a patient), please sign and date the ***Permission to Use Likeness*** form.

We appreciate your willingness to help us tell the story of Atrium Health and the work that we do every day to improve lives. Thank you!

Authorization to Use and Disclose Information for Communications and Marketing

This form authorizes us to use and disclose your patient/health information as described below.

Full Patient Name: _____ **Date of Birth:** _____

Who can use and disclose patient information	Atrium Health (including its Corporate Communications, Marketing & Outreach department and contractors), and its associated foundations, entities, affiliates, and locations (collectively, "Atrium Health")
Types of patient information we can use and disclose	You give Atrium Health permission to use and disclose any health information in any form (print, photograph, audio/oral, interview, video, digital, televised, posted, streamed, and other electronic forms), that we think is relevant about you and your health care, including your name, age, city of residence, illness/injury, your story, how we cared for you, and your image, including any photographs, videos, or recordings in which you appear.
What we can do with your information (purpose)	Atrium Health can use and disclose your information to share your patient story internally and externally, to market Atrium Health and promote our services, to educate others about health issues and care, and to publish articles and give presentations. We may communicate your information in newspapers, magazines and other publications; radio, podcast, and television broadcasts; internet and intranet sites; marketing and public relations materials/publications; social media outlets; and in patient or public education materials and brochures.
With whom we can share your information	Atrium Health can disclose your information to: local, regional, or national media outlets, including on social media; the public; Atrium Health marketing and communication recipients; associated Atrium Health Foundations; and other third parties designated by Atrium Health.
How long this Authorization lasts	This Authorization will expire when Atrium Health no longer needs the information. Please note that uses and disclosures involving your information made or issued before the expiration date cannot be retracted, especially if they were already released publicly.

Please also understand that:

- Refusing to sign this form will not interfere with your ability to receive treatment, payment, enroll in our health plan, or be eligible for benefits from Atrium Health if available.
- You can cancel this Authorization at any time by sending written notice to Atrium Health Corporate Communications, Marketing, and Outreach, PO Box 32861, Charlotte, NC 28232-2861. Cancellations will apply only to information not yet used or disclosed by Atrium Health. Note that once Atrium Health uses and discloses your information, the person or entity receiving it may disclose or share that information with others and it may no longer be protected by federal and state privacy protections.
- Atrium Health will not share or use your health information without your authorization other than as required by law or in the ways listed in the Atrium Health Notice of Privacy Practices, available at www.carolinashealthcare.org.
- You have a right to receive a copy of this form upon request.

Signature: _____

Patient Name: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit Next of Kin ☐ Other: _____

Patient Label

Permission to Use Likeness

This form gives us permission to use your stories, image, voice, etc. under intellectual property laws. It is separate from the Authorization, which gives us permission to use and disclose your information under patient privacy laws.

I grant The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health and its associated foundations, even if separately incorporated (collectively, "Atrium Health") a perpetual, world-wide, royalty free license and permission to record, use, disclose, portray, reproduce, broadcast, stream, post, print, and publish my (or the person on whose behalf I am serving as a personal representative, who will be included in the terms "my", "me", "mine", or "I") likeness, picture, video, information (including that released pursuant to an Authorization), story, quotes, and interview, whether in digital, electronic, paper, print, video, oral, or televised form ("Information") for Atrium Health's current or future internal and external marketing, fundraising, public relations, and educational purposes on behalf of Atrium Health (including on behalf of its hospitals, practices, programs, and associated foundations). I understand that such Information will be the exclusive property of Atrium Health, free and clear of any claim on my part and may be used in future video or print projects, in whole or in part.

I understand that I will not be compensated for the permissions, licenses, or use of the Information. I also understand that Atrium Health is only responsible for its own actions, and does not control third parties, including other media outlets. I understand that I can request that production of the recording be stopped at any time during production and I can revoke this Permission before the Information is used. On behalf of myself, my child, our heirs and representatives, I agree to release Atrium Health, their commissioners, directors, officers, and employees, from and against any liability related to their use of the Information.

Signature: _____

Patient Name: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit Next of Kin ☐ Other: _____

Patient Label