



HOSPICE of the North Coast

Hospice of the North Coast ~ The HOPE Bereavement Center

2525 Pio Pico Dr., Carlsbad, CA 92008

Phone: (760) 431-4100 • Fax: (760) 431-4133 • www.hospicenorthcoast.org

Camp H.O.P.E. 2011 Family Registration Form

Name of Responsible Adult _____

Relationship to Children _____

Hm Phone _____ Wk/Cell Phone _____

Email (important) _____

Address _____

City _____ State _____ Zip _____

New to Camp Returning Family # of times attended camp _____

A screening interview is required for each new family member attending. Please list names and complete information below for ALL who will be attending camp, including responsible adult(s) listed above.

Name	Age	Gender	Relationship to Deceased

Who Died? _____ Cause _____ Date _____ Sudden Y N Traumatic Y N
 Who Died? _____ Cause _____ Date _____ Sudden Y N Traumatic Y N
 Who Died? _____ Cause _____ Date _____ Sudden Y N Traumatic Y N
 Who Died? _____ Cause _____ Date _____ Sudden Y N Traumatic Y N

If traumatic, please describe _____

Are there any other major changes for the family since the death? (Include divorce, moves, change of schools, new health problem, unemployment, financial hardship, loss of pet, loss of relationship, etc.) _____

Family Registration Form (continued)

Was the person who died served by Hospice of the North Coast? Yes No

Please list the name of each child who is experiencing any of the following, such as: special needs, allergies, hearing aids, asthma, seizures, autism; or emotional, behavioral or psychiatric problems; ADD or ADHD; or anything else you think we should know.

The health and bereavement history information included in this packet are completed correctly so far as I know, and the children herein described have my permission to participate in the planned camp activities, except as noted. If one of these children appears to be ill, I will not send him/her to the program. I give permission for general first aid to be administered to these children. I give permission to Hospice of the North Coast to share the information contained in this registration packet with Camp H.O.P.E., counselors and volunteers who will be working with these campers.

_____ Date _____
Signature of Responsible Adult (please specify if parent or guardian)

Please mail your \$50 non-refundable registration fee along with the Family Registration form, the Informed Consent, Release and Indemnification Agreement and the Family Confidentiality form to Hospice of the North Coast, Camp H.O.P.E., 2525 Pio Pico Dr, Carlsbad, CA 92008. Checks should be made payable to Hospice of the North Coast.

Please check here if you require financial assistance to attend Camp H.O.P.E. Scholarships are available by request.

Thank you.

HOPE Bereavement Center



HOSPICE of the North Coast

Hospice of the North Coast ~ The HOPE Bereavement Center

2525 Pio Pico Dr., Carlsbad, CA 92008

Phone: (760) 431-4100 • Fax: (760) 431-4133 • www.hospicenorthcoast.org

Camp H.O.P.E.

Family Confidentiality Policy

Camp H.O.P.E., of Hospice of the North Coast is pleased that you and your family have decided to make Camp H.O.P.E., a part of your healing process. We would like you to be aware of the following policies:

1. The Camp H.O.P.E., staff is made up of Hospice of the North Coast professional staff as well as trained volunteers and counselors from the community. Our goal is that camp will be a positive and healing experience for you and your family. One way we can accomplish this goal is by protecting your confidentiality. Your communication with camp personnel is strictly confidential. We must have your written permission to release or obtain any information concerning you. Exceptions to this policy include:
 - A. Mandatory reporting of any possible child/elder abuse
 - B. The clear possibility of harm to yourself or other persons
 - C. Court ordered release of records

In these cases, California law requires that confidentiality be breached only to the extent necessary to comply with law enforcement or to ensure the safety of the individual(s) involved.

2. It is expected that during camp, personal information will be discussed. In order to make this comfortable for everyone it is our policy to ask all camp participants to honor confidentiality as well. It is imperative that what is discussed at camp that is of a private or personal nature concerning other participants be kept private and confidential and therefore not repeated to anyone including names or identifying information.

Please sign below indicating that you have read, understand and agree to the above policies. The signature of a parent or guardian indicates that you have explained the above policies to your children and will assist them in maintaining confidentiality.

Parent/Guardian Signature _____

Date _____



HOSPICE of the North Coast

Hospice of the North Coast ~ The HOPE Bereavement Center

2525 Pio Pico Dr., Carlsbad, CA 92008

Phone: (760) 431-4100 • Fax: (760) 431-4133 • www.hospicenorthcoast.org

Camp H.O.P.E.

Informed Consent, Release and Indemnification Agreement

1. I, _____, hereby give permission for my child/children _____ to attend Camp H.O.P.E. I understand that the camp's goal is to help educate about the bereavement process to facilitate and support my family through supportive, healing and fun activities, ceremonies and entertainment.

2. I give permission for my family to be photographed and/or videotaped during Camp H.O.P.E. I understand that these photographs and/or videotapes will remain the property of Camp H.O.P.E., at Hospice of the North Coast and they may now or in the future be used for promotional and/or educational purposes.

___ Yes ___ No

3. In consideration of the above named child/children being granted permission to attend Camp H.O.P.E.:

I, for myself and on behalf of my child/children, release and discharge Camp H.O.P.E. and Hospice of the North Coast, its agents, employees, volunteers and officers, from any and all claims, demands, actions and judgments which I or my child/children ever had, now have, or may have against Hospice of the North Coast for personal injuries, either physical or emotional, known or unknown, and injury to property, real or personal, sustained by me or my children's person or property during our attendance at Camp H.O.P.E., whether the injury is caused by negligence or any other fault.

4. Also, in consideration of the above-named child/children being granted my permission to attend Camp H.O.P.E.:

I, agree to indemnify and hold harmless Camp H.O.P.E., and Hospice of the North Coast for any and all claims, demands, actions, and judgments whatsoever of every name and nature, both in law and equity, which I or my child/children ever had, now have or may have against Camp H.O.P.E., and Hospice of the North Coast for personal injuries, either physical or emotional, known or unknown, and injury to property, real or personal, sustained by me or my children's person or property during our attendance at Camp H.O.P.E., caused by or arising from Camp H.O.P.E.'s or Hospice of the North Coast's negligence.

I, the undersigned, have read this release, agree to and understand all of its terms.

Parent/Guardian Signature _____

Date _____



HOSPICE of the North Coast

Hospice of the North Coast ~ The HOPE Bereavement Center

2525 Pio Pico Dr., Carlsbad, CA 92008

Phone: (760) 431-4100 • Fax: (760) 431-4133 • www.hospicenorthcoast.org

Camp H.O.P.E. Health History Form

*Please complete one form per child

Child's Name: _____
LAST FIRST MIDDLE

Home Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____ Gender: Male Female

Mother/Guardian Name: _____

Home Phone: _____ Cell: _____ Work: _____

Father/Guardian Name: _____

Home Phone: _____ Cell: _____ Work: _____

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

Health History (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Allergies (food, animals, etc.) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Convulsions/seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Heart disease/problems | <input type="checkbox"/> Kidney disease/problems |
| <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Motion sickness |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Special dietary needs | <input type="checkbox"/> Wears contact lenses |
| <input type="checkbox"/> Wears eyeglasses | <input type="checkbox"/> Other (specify below) |

Please explain in detail any areas which have been checked above:
