



at
Victory Junction
October 14, 2017
9:00am-4:00pm

Teen Bereavement Event
Enrollment Application

Call (336) 672-9300 with questions or for information.

Mail completed application with \$10 registration fee to:

Hospice of Randolph County

PO Box 9

Asheboro, NC 27204

~or~

Contact 336-672-9300 for other arrangements, or visit our website
(www.hospiceofrandolph.org) to pay by credit/debit.

Financial Assistance is available; Please contact us to discuss needs.

SOAR is a bereavement event for teens, grades 7-12. Any teen who has experienced the loss of a loved one is invited to attend. Participants will learn about ways to cope with grief and loss, while making new friends and experiencing the excitement of Victory Junction.

*****IMPORTANT INFORMATION*****

- **\$10 Registration Fee is due at the time of application.**
Applications and registration fees for SOAR must be submitted to KidsPath at Hospice of Randolph County **no later than September 14, 2017.**
- Registration scholarships are available as needed. You may contact Kids Path at 336-672-9300 with any questions or for more information.

On the day of Event:

- Registration will begin at 8:30am at Victory Junction, 4500 Adam's Way, Randleman, NC 27317.
- Participants should wear clothing that is comfortable and that they would not mind getting dirty. Please dress for outdoor adventures, and wear comfortable shoes. Each participant will receive a special event T-shirt when they arrive.
- We will provide lunch, snacks, and water throughout the day.

*****SOAR WILL BE HELD, RAIN OR SHINE*****

SOAR
the adventure awaits...
October 14, 2017
A Bereavement Event for Teens, Grades 7-12
Enrollment Application

Participant's Name _____

Date of Birth _____ Age _____ Phone: _____

Address _____

(CITY) (COUNTY) (STATE) (ZIP)

Name of school _____ 2017-18 grade level _____

How did you hear about SOAR? _____

Name of person who died _____ Age _____

Relationship to participant _____ Date of Death _____

Cause of death _____

Was participant present at death? ___ Did they live with the person who died? ___

Please describe their relationship _____

Have there been other changes/ stresses in participant's life (divorce, remarriage, relocation, illness)? _____

Is participant having any specific difficulty in school or in relationships with others? I.e.: inappropriate behavior, aggression, and withdrawal, etc.

(Enrollment Application Continued)

In addition to the loss described above, what other deaths/losses has the participant experienced and when? _____

What are your expectations of SOAR? _____

Participant's hobbies and interests _____

Has participant been in any grief support or sought counseling? If yes please explain.

Name and ages of other household members _____

Briefly describe participant's personality _____

Participant's T-shirt size (circle):

Adult Small Adult Medium Adult Large Adult XL Adult 2XL Adult 3XL

Parent/ Guardian signature _____

Relationship to participant _____

All information is confidential per our policies as explained herein.

SOAR
Parent/Guardian Consent and Liability Release Form

The undersigned does hereby give permission for our (my) child, _____, to attend and participate fully in the activities of SOAR/KidsPath. We (I), _____, authorize an adult, in whose care the minor has been entrusted, to consent to any X-Ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under general or special supervision and on the advice of any physician or dentist licensed under the provision of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all cost and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

The undersigned also gives permission for their child to ride in any vehicles designated by the adult in whose care the minor child has been entrusted while attending and participating in activities sponsored by KidsPath.

In consideration for being accepted by KidsPath for participation in SOAR activities, we (I) being 21 years of age or older, do for ourselves (myself) (and for and on behalf of my child- participating) hereby release, forever discharge and agree to hold harmless SOAR, KidsPath, Hospice of Randolph County, and the directors there of from any liability, claims and demands for personal injury, sickness or death, as well as the damage, and expense of any nature whatsoever which may be incurred by the undersigned and the child-participant in the above described event.

Furthermore we (I) _____ and on behalf of our (my) child participant hereby assume all risk of personal injury, sickness, death, damage and expenses as a result of participating in recreation and activities involved therein.

Further, authorization and permission is hereby given to said event to furnish any necessary transportation, food and lodging for this participant.

The undersigned further hereby agree(s) to hold harmless and indemnify said event, its directors, employees and agents, for liability sustained by said event as the result of the neglect, willful or intentional acts of said participants, including expenses incurred attendant thereto.

Further should it be necessary for the participant to return to home due to medical reasons, disciplinary action or otherwise, we (I) will arrange for transportation home.

Parent/Guardian signature _____

Date _____

SOAR

General Confidentiality Policy

Policy: Strict confidentiality of all SOAR teen bereavement event participant information is to be maintained at all times. Any information received that either directly or indirectly relates to SOAR participants is privileged and not subject to disclosure.

Confidential participant information includes, but not limited to:

- Participant's name
- Scope and nature of concern/loss
- Nature of attendance
- Medical, mental health, substance abuse or developmental disability histories.
- Any information that will be adverse to health, safety, or reputation of the participant's or his /her family or significant other.

I have read, understand, and agree to abide by the SOAR confidentiality policy as stated above. I understand that all information obtained through interview(s) or event visit is considered confidential. I understand that all information that is part of the participant/family record is considered confidential. I agree to respect the principle of confidentiality. Unauthorized disclosure of the confidential information is a crime punishable by the court and/or civil penalties.

Parent/Legal Guardian Signature

Date

Participant's Health History

A team of nurses will be on-site during SOAR to administer medication and attend to any medical needs. Please provide the following information regarding your child's Health History and Medications.

SOAR Participant _____
Hospital Insurance _____ Yes _____ No
Preferred Hospital _____
Insurance Company _____
Policy Number _____ Group# _____ Effective Date _____
Physician Name _____ Phone Number _____
Parent /Guardian Name _____
Address _____
Phone Number(s) _____
If Parent/Guardian is not available in an emergency, contact:
Name _____ Relationship _____
Address _____ Phone _____

Health Conditions (Check), Allergies (Check), Diseases (approx.date):

Frequent ear infections _____ Hay Fever/Sinus _____ Chicken Pox _____
Heart Defect/ Disease _____ Ivy Poisoning, etc _____ Measles _____
Asthma _____ Insect Stings _____ German measles _____
Diabetes _____ Penicillin _____ Mumps _____
Behavior Problems _____ Food _____ (explain below) Hepatitis _____
Epilepsy _____ Other _____
Physical Limitations _____

Please explain any that are checked: _____

Operations or serious injuries: (dates) _____
Chronic/recurring illness (physical, emotional) _____

Any prescribed meal plan, dietary restrictions, or food allergies: _____

Medication Information

May the Health Care Staff administer Tylenol? () Yes () No

If not, please name an alternative_____

Does participant take any medications? () Yes () No

If yes, please provide information below.

Medication name_____

Dosage/Frequency_____

How administered? (Orally, Injection, etc.)_____

Medication name_____

Dosage/Frequency_____

How administered? (Orally, Injection, etc.)_____

Medication name_____

Dosage/Frequency_____

How administered? (Orally, Injection, etc.)_____

Medication name_____

Dosage/Frequency_____

How administered? (Orally, Injection, etc.)_____

ALL PRESCRIPTION MEDICATIONS MUST BE BROUGHT TO EVENT IN THEIR ORIGINAL CONTAINER FROM THE PHARMACY, PROPERLY LABELED WITH CURRENT DOSAGE. ANY CHANGES FROM THOSE ON THE CONTAINER MUST BE VERIFIED IN WRITING BY A PHYSICIAN. ALL MEDICATION MUST BE TURNED OVER TO THE HEALTH CARE STAFF AT REGISTRATION THE MORNING OF EVENT.

I hereby give my permission to the SOAR medical staff to administer regular medications, or any needed over-the-counter medication and provide on-site care for my child.

Parent/Guardian_____

Date_____