



**A Teen Bereavement Event at  
Camp Caraway  
April 6, 2019  
9:00am-3:00pm**

**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 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 nature and excitement of Camp Caraway.**

**\*\*\* 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 March 6, 2019.**
- 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 **Camp Caraway, 4756 Caraway Mountain Rd, Sophia, NC 27350.**
- Participants should wear clothing that is comfortable, appropriate for outdoor weather, and that they would not mind getting dirty. All participants must wear closed toe shoes but they may also bring water shoes/sandals for fun on the lake.
- Participants 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\*\*\***

**Participant's T-Shirt Size (circle):**

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



**Enrollment Application**

Participant's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
(CITY) (COUNTY) (STATE) (ZIP)

Parent/Guardian's Name \_\_\_\_\_

Email Address \_\_\_\_\_

Name of school \_\_\_\_\_ 2018-19 grade level \_\_\_\_\_

How did you hear about SOAR? \_\_\_\_\_

Name/Relationship/Age of person who died \_\_\_\_\_

Cause of death \_\_\_\_\_ How recent? \_\_\_\_\_

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

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.  
\_\_\_\_\_  
\_\_\_\_\_

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

What are your expectations of SOAR? \_\_\_\_\_

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



## 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 \_\_\_\_\_

Relationship to participant \_\_\_\_\_

Date \_\_\_\_\_

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## 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/Legal Guardian signature \_\_\_\_\_

Date \_\_\_\_\_



(336) 672-9300

## Participant's Health History

A nurse 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 \_\_\_\_\_



## Media and Communications Permission Form

To communicate the Kids Path mission and message, I give permission for Hospice of Randolph County and Kids Path to use photos, videotapes, quotations, stories, artwork, and other artistic expressions of the children and teens served through Kids Path for purposes including but not limited to display boards, social media marketing, event promotions, brochures, newsletters, lectures and training sessions. The names of children and detailed information about children will not be spoken, shared, or printed. By signing this form, I give permission for Hospice of Randolph County and Kids Path to utilize this content without my pre-approval, knowing that it will only be utilized to further the Kids Path mission.

\_\_\_\_\_ We give permission to the above uses of pictures, photos, artwork, quotations, stories, and videotapes.

\_\_\_\_\_ We give our permission with the following exceptions:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ We do **Not** give permission to any of the above.

Child(ren) Name(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date