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.

(336) 672-9300

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 13, 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

(336) 672-9300

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.

____

(336) 672-9300

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 ___________________________

(336) 672-9300

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____________________

<u>Health Conditions (Check), Allergies (Check), Diseases (approx.date):</u>

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: ___________________

____

(336) 672-9300

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 ORGINAL 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 herby 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_______________

(336) 672-9300

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