Dear Parents and Guardians,

We are excited to announce that Ryan's Place will be offering a one day grief camp this summer. This camp will be open to children who have completed grades 1st-7th and have experienced the death of a loved one at some point. The death does not necessarily have to be recent in order for a child to benefit from the camp.

The camp will take place on Saturday July 15th from 8:30 am-1:00pm. Lunch will be provided to all who attend. While the children are at camp they will have the chance to work with other children to share experiences and feelings, and begin the long journey that is grieving the death of a loved one. The camp will be activity based and will help facilitate discussion between children about many of the complicated issues that arise after the death of a loved one.

Enclosed in this packet are several forms that must be filled out, signed by a parent or guardian, and returned to Ryan's Place on or before **Friday, June 30th, 2017.** You may mail the forms or drop them off at Ryan's Place. **The space in the camp is limited to 24 children and children will be admitted on a first come first serve basis**. Below is a list of the forms that must be singed and returned in order for your child to be able to participate in our grief camp.

Check list of forms:

- **Registration Form**
- **Medical Registration Form**
- **Permission Form**

If you have any questions about camp or about the registration process please call me at 574-535-1000 or email me at lhamlin@ryansplace.org. We look forward to working with you and your children this summer.

Sincerely,

Laurenne Hamlin
Program Director

Mailing information
Ryan's Place
P.O. Box 73
Goshen, IN 46527

As a parent or guardian of _____ (DOB)_____, I give full permission for my child to participate in any Ryan's Place activities conducted as part of the Camp Hope program.

I affirm that the medical information I have provided is accurate and complete. I understand that failure to disclose this information could affect the safety of my child and the safety of those around my child. I agree to hold Ryan's Place harmless if full disclosure of a pre-existing condition has not been provided. In the event of illness or injury, consent is hereby given to provide emergency medical care, hospitalization, or other treatment deemed necessary.

I understand each participant must assume the risk of injury or disability that could result from any activities.

I release Ryan's Place, it's staff members, volunteers and Board of Directors, from all liability for any injury to my child from participation in Ryan's Place Camp Hope activities.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date

I _____ understand that parts of the Ryan's Place Camp Hope program may be physically or emotionally demanding. I agree to follow all safety instructions given by Ryan's Place staff during my participation in the camp.

_____ _____

Child Signature Date

Camp Hope Registration Form

Parent/Legal Guardian Information:

Legal Guardian (s) names: _____Date: _____

Relationship to the child (ren): _____

Address: _____

Street City State Zip Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

EMERGENCY CONTACT: _____ Phone _____

Children who will be attending camp:

Name: _____ M/F DOB:_____ Age:____ Grade:_____
Current Medications/Allergies: _____ Group:_____

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Current Medications/Allergies: _____ Group:_____

How did you learn about Ryan's Place Camp?

_____

Bereavement Information

Name of the person who died: _____

Relationship to the child (ren): _____

Birth date (if known): _____ Death date: _____ Age: _____

Cause of death: Natural Accidental Suicidal Homicidal

Explain:_____

Was the child/children living with this person at the time of death? Yes or No

If not, how long has it been since the child/children last saw this person? _____

Was the child/children present at time of death? Yes or No Note:_____
Has the child/children been told everything about the death? Yes or No Note:_____

Was the child/children involved in the funeral and burial? Yes or No Note: _____

Please check any changes which have occurred for the child/children since the death of this person:
__ Moved to a new home __ Changed schools __ Parent has new job
__ Family's finances have suffered __ Parent has new relationship or remarriage

If your child has experienced any of the following, since the death, please check:
__ Increased Anxiety __ Depression __ Difficulty going to school __ Disturbed Sleep
__ Difficulty Concentrating __ Anger Outbursts ___ Increased Tearfulness
__ Physical symptoms (list) _____
__ Other behavior changes (list) _____

What, if any, counseling or peer support has your child/children received?
_____
_____

Please use this space to share any concerns or information you want Ryan's Place to know about your child/children:
_____
_____
_____
_____

Ryan's Place Demographic Information

The following information will be used for funding purposes only. It will never be released to any other person, group or agency.

Annual family income: $_____

Racial/Ethnic origin: (circle all that apply)

Hispanic African American
Caucasian American Indian
Asian Indian Japanese
Chinese Korean
Vietnamese Other: _____

County of residence: _____ Number in household: _____
School district/system _____
Do you receive Free/Reduced School Lunches (circle one): yes no

Medical Information Form

Name:	Grade:	Referred by:
School:	Ethnicity:	Gender:
Ht:	Wt:	Hair Color:
Eye Color:	Distinguishing marks:	

Mother's Name:	Doctors Name & #:
Father's Name:	Dentists Name & #:
Emergency contact name & #:	Specialist Name & #:
Siblings name & age:	
Medication & Doses:	Insurance Company:
	Policy Holder:
	Policy Holder DOB: Policy Holder SS#
	Employer:
	Policy #
	Group or Plan #

Health History: if your child has any of the following conditions please indicate with a check mark in the box:

	YES	NO		YES	NO		YES	NO	Other Diagnosis:
Heart Problems			Hepatitis			Head injury			
ADD/ADHD			Blood clotting disorder			Frequent headaches			
Anemia			Cancer/Leukemia			Scoliosis			
Activity restrictions			Frequent ear infections			Vison issues			
Depression			Anxiety related vomiting			Stomach problems			
OCD			Frequent constipation			Physical disabilities			
Arthritis			Diet restrictions			Hearing loss			

Please explan all "Yes" answers:

Does your child have asthma/breathing proglems? ☐Yes ☐No If yes, a Asthma Action Plan is required prior to admission.

Does your child have allergies (medication, food, environmental, bee etc...)? ☐Yes ☐No If yes, an Allergy Action Plan is required prior to admission and please list all allergens:

Is your child prescribed an Epipen? ☐Yes ☐No If yes, a self-carry administration or medicine form is required.

Does your child have diabetes? ☐Yes ☐No If yes, an individualized Emergency Action Plan for Diabetes in school is required to admission.

Does your child have seizures? ☐Yes ☐No If yes, a Seizure Action Plan is required to admission.

We (I), the parent(s)/guardian(s) of:_____

☐ Request that the above named specialized physical health care Ation Plan(s) are to be administered to our child. We understand that Ryan's Place does not have a nurse on site and a non-licenensed person(s) will be performing the health care services as directed by our child's physician. We understand that we are responsisble for providing/bringing all necessary supplies and equipment to camp, correctly labeled, with the proper directions ur use. We will notify the Ryan's Place immediately if our child's health status changes, we change physicians or the Action Plan is changed or is canceled. We understand that any change in the Action Plan must be received in writing from the ordering physician listed above. We understand that, whenever possible, the medical and dental appointments must be provided before camp begins.

☐ Request that if a need should arise you will provide over-the-counter medications to my child, which will be provided by Ryan's Place. All over-the-counter medication shall be administered by a non-licensed person(s) according to the package directions.

☐ Request that my child be assisted in taking the prescription medication(s) listed aabove. We understand that we are resonsible for providing and bringing all necessary prescription medication to school in its original container; with the proper directions for use. We will notify Ryan's Place immediately if there are changes in the medication dosage, directions, or if it is discontinued.

☐ The Program Director has our/my permission to speak with the physicians, dentis, school and agencies listed above regarding my child.

Parent Signature: Date: