Dear Parents/Guardians:

We are excited about your interest in Camp Erin® South Florida!

Camp Erin is a FREE weekend bereavement camp for children and teens ages 6 to 17 who are grieving the death of a significant person in their lives. Camp Erin combines grief education and emotional support with fun traditional camp activities. Our grief professionals and trained volunteers provide a caring and supportive environment for campers to explore their grief, learn essential coping skills, and make connections with peers who are also grieving.

Typically, Camp Erin is a overnight weekend camp (Friday to Sunday), however, due to the ongoing COVID-19 pandemic, we developed a program where campers can still receive support, process their grief and make meaningful connections, while ensuring the health and safety of our campers, volunteers and staff. We are working toward returning to our overnight camp program. In the meantime, all steps in the application process will be done virtually online or over the phone.

In order to register your child(ren) for Camp Erin, we require the following steps:

1. **Application** – Complete and submit a Camper Application (**one application per child**). E-mail completed applications to **CampErin@catholichospice.org.** When submitting your application, please attach a **copy of your child's health insurance card** (if applicable).

2. **Interview** – After receiving your application, a Camp Erin team member will contact you to schedule a Family Interview to: review your application, help familiarize you and your child(ren) with our camp programming, and most importantly, to get to know your child(ren). The interview will us determine your child's readiness for camp and if Camp Erin fits their needs.

3. **"Save Your Spot" Orientation** – At "Save Your Spot," you and your campers will get to meet the Camp Erin team and other campers and their families, while confirming your spot(s) at camp. Your attendance is **required**. Details to follow the Family Interview.

If you have any questions or need assistance, please contact me at (**786) 920-2991** or by e-mail at **gsantayana@catholichospice.org**.

Sincerely,

Gian Carla Santayana, MS, LMFT
Manager, Special Programs
Catholic Hospice, Inc.
2900 West Cypress Creek Road | Suite 7 | Fort Lauderdale, FL 33309
O. 954-944-2709 | C. 786-920-2991 | gsantayana@catholichospice.org
www.camperinsouthflorida.org

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PART OF THE ELUNA NETWORK

Please indicate the camp you are applying for: (Check one)

- ☐ March 26-27, 2022 @ Hugh Taylor Birch State Park (Sunrise, FL)
- ☐ October 21-23, 2022 @ Camp Owaissa Bauer (Homestead, FL)

CAMPER APPLICATION CHECKLIST

Child's Name: _____ **Gender:** _____

Date of Birth: _____ **Age:** _____

Child's Mailing Address: _____

T-Shirt Size: (Check one) ☐ Child Small ☐ Child Medium ☐ Child Large ☐ Adult Small ☐ Adult Medium ☐ Adult Large ☐ Adult XL

Race/Ethnicity: (Circle all that apply)

☐ Black/African American ☐ White/Caucasian ☐ Hispanic/Latino ☐ Asian ☐ Multiracial

Principal concerns: _____

What would you hope that your child would gain from attending Camp Erin? _____

_____

Attended Camp Erin before? (Check one) ☐ Yes ☐ No ***If Yes, Year/Location?*** _____

If yes, what would your like your child to gain this time from attending Camp Erin? _____

_____

Have you talked to your child about the possibility of attending Camp Erin? (Circle one) ☐ Yes ☐ No

Military Affiliation: (Check one) ☐ Yes ☐ No ***If Yes, which Branch?*** _____

Does the camper applicant qualify for or receive free or reduced lunch at school? (Check one) ☐ Yes ☐ No

Was the deceased a significant caregiver of the camper? (Check one) ☐ Yes ☐ No

Person Completing Application: _____ **Relationship to Child:** _____

E-mail: _____ **Phone Number:** _____

How did you hear about Camp Erin? _____

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BEREAVEMENT HISTORY

Please include as many details as possible when answering the following questions. We understand that answering some of these questions might be difficult; however, we want to be able to provide the best possible care for your child.

Child's Name _____ **Child's age** _____

Full name of deceased _____ **Relationship to child** _____

Date of death _____ **Age of deceased at time of death** _____

Was the death anticipated or sudden? _____ **Cause of death** _____

Please describe how the death was explained to the child: _____

How you describe your family's communication style regarding the death? (Check one)

☐ Open ☐ Adequate ☐ Very Little ☐ Avoided ☐ None

Please check if either of the following statements are TRUE:

☐ Child/Adolescent was present at time of death.

☐ Child/Adolescent does not understand the facts about the deceased's cause of death.

☐ Child/Adolescent currently receives professional support. If so, explain: _____

☐ This is not child's first experience with death. If so, explain: _____

Please indicate other changes/stresses in child/adolescent's life (i.e., illness, relocation, divorce, history of abuse, remarriage, finances, other losses) _____

Please explain how your child indicates that he/she is grieving. Do they speak openly about the person who died? _____

Reaction to Loss: (Check all the behaviors your child has exhibited following the death of the loved one)

☐ Withdrawn/Isolation
☐ Depression/Sadness
☐ Suicidal thoughts/talk
☐ Nightmares
☐ Other: _____

☐ Drug/Alcohol Use
☐ Causing harm to self/others
☐ Anger/Aggressiveness
☐ Crying Spells

☐ Fearful of _____
☐ Believes that death was his/her fault
☐ Believes that death is punishment
☐ Separation Anxiety

Difficulty with: (Check all that apply) ☐ Energy ☐ Weight ☐ School Attendance ☐ Self-esteem

Describe your child/adolescent's personality and any special needs (language, disability, and/or religious needs), family customs, cultural aspects, concerning behaviors/moods that we should be aware of to better serve your child.

_____

_____

_____

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MEDICAL INFORMATION

Child's Name: _____ **Date of Birth:** _____

Address: _____ **Phone Number:** _____

Does your child: (Check one)

Have physical limitations?	☐ Yes	☐ No	*If yes, specify: _____
Wear glasses/contacts?	☐ Yes	☐ No	
Have allergies?	☐ Yes	☐ No	*If yes, specify: _____
Dietary Restrictions?	☐ Yes	☐ No	*If yes, specify: _____
Have significant medical history?	☐ Yes	☐ No	*If yes, specify: _____
Take medication?	☐ Yes	☐ No	*If yes, specify: _____

Is your child under the care of a Primary Care Physician (PCP)? (Check one) ☐ Yes ☐ No

Child's PCP Name: _____ **Phone Number:** _____

Physician Address: _____

Is there a hospital that your insurance mandates? (Check one) ☐ Yes ☐ No

If yes, what is your hospital of choice: _____

In case of an emergency, please contact the following persons (in order):

Emergency Contact Name: _____

Home Phone Number: _____ **Cell Phone Number:** _____

Emergency Contact Name: _____

Home Phone Number: _____ **Cell Phone Number:** _____

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Consent for Medical / Surgical Care, Emergency Treatment and Medical Information

Child's Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____ **Relationship to Child:** _____

As the parent/legal guardian of the above named child, I give full authorization to Camp Erin® staff or agents to secure medical care or treatment for said youth. This treatment may include assistance from the nearest physician, medical clinic, hospital, trained nurse, EMT, or other health care professional in the event of illness or injury that requires immediate attention as determined by Camp Erin staff. In the event of an emergency and I cannot be contacted, I give permission to the treating medical institution and/or medical providers to render any medically necessary care for my child. I further authorize Camp Erin and its agents to disclose any and all information they deem appropriate and as necessary to secure appropriate care for my child. I agree that I am responsible for any such care rendered to my child and will indemnify and hold harmless Camp Erin for such care or related costs or expenses.

My child has the following health issues and/or problems: _____

_____

_____

***If none, please write "none"**

List all medications (prescription/non-prescription) that your child will need to take while at camp:

Name of medication	Dose	Frequency	Prescribing Physician	Reason for taking

***When bringing medication to camp, all medications must be in their ORIGINAL containers**

Child's allergies (i.e., food, medication, and all other allergies) and indicate reactions: _____

_____

_____

Does your child have medical insurance: (Check) ☐ Yes ☐ No ***If yes, please complete below.***

Name of Health Insurance Carrier: _____ **Phone Number:** _____

Policy Holder's Name: _____ **Policy & Group Number:** _____

Signature of Policy Holder: _____ **Date:** _____

PLEASE MAKE COPY OF INSURANCE CARD AND ATTACH TO FORM

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Custody Release Form

Name of Camper: _____

Camper Date of Birth: _____

I am the parent or legal guardian of the child camper identified above. I hereby authorize and direct Camp Erin®, its staff, and/or its volunteers to release the child camper to the following person(s) during or at the end of Camp Erin for purposes of transporting or otherwise assuming custody of the child camper:

Name: _____

Address: _____

_____

Phone Number: _____

Cell Phone Number: _____

E-mail: _____

If it is necessary for my child to leave Camp Erin before the end of the program due to illness, injury, or behavioral issues, and I cannot be reached, I hereby give permission for my child to be released into the custody of the person identified above. I understand that Camp Erin may require photo identification of anyone who picks up the child camper from Camp Erin, including myself.

I herby release Camp Erin, its staff, volunteers and representatives from liability for releasing the child camper to the person identified above.

I understand and agree that, in the event of necessary health care or other emergency, Camp Erin may release my child to health care professionals or other appropriate personnel.

I have read and understood this entire form, and I agree to be bound by the conditions of the agreement.

_____ _____

Signature of Parent/Guardian **Date**

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Privacy Release Statement

I, the undersigned, am guardian of _____ and do hereby voluntarily participate and give authorization for the minor child to appear in photographs and/or interviews with respect to Camp Erin® and its activities.

I do hereby consent to the use of the above materials in any form of media (publications, radio, television or internet). I also understand that my identity may be disclosed in connection with the photographs and/or interviews.

I do hereby release, Catholic Hospice, Catholic Health Services and the Archdiocese of Miami, its agents and employees from all liability in connection with the above. I waive any right to inspect or approve the finished product, the advertising or other copy that may be used in connection with the above.

I hereby consent to the above, without expectation or remuneration to me now or in the future. The agreement shall be binding upon my heirs, personal representatives and assigns.

Print Name/Parent or Legal Guardian	**Print Name/Catholic Hospice Rep.**
Signature	**Signature**
Date	**Date**

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