CAMP STAR

SHARING TOGETHER & REMEMBERING

Application Due Friday, July 13

Camp STAR is a program of STAR Children's Bereavement Services, in partnership with Bay Cliff Health Camp.

The following information will be used by those involved in your child's experience during the camp weekend to ensure the safest and best possible care. Please answer the questions as completely as possible. All applications are kept confidential. If necessary in the application process, permission may be requested from the parent/guardian to release medical or professional reports to STAR Children's Bereavement Services and Bay Cliff Health Camp.

Camper's Full Name: _____ Preferred Name: _____
Birth Date: _____ Age in August of this year: _____ Gender: _____

Name of Parent/Guardian: _____ Parent: __ Guardian:__
Home Address : _____
Email address: _____
Cell Phone: _____ Home Phone: _____Work Phone: _____

In case of an emergency, please notify:
Name: _____ Relationship: _____
Home Address: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____

Additional contact or responsible party that may be contacted or pick up camper:
Name: _____ Relationship: _____
Preferred Phone Number: _____

Name (or nickname) of the loved one who died: _____
Relationship: _____ Date of the Death: _____ Age of the camper at that time: ___
Please explain the circumstances about the loved one's death that would help us to understand the child's emotions (where did it happen, was the child present, did the child understand/say goodbye, etc.):_____
_____
_____
_____
_____

Did the child attend the funeral/memorial service: If so, what was the child's reaction?
_____
_____
_____
_____

Have there been multiple deaths of loved ones experienced by the child? _____
If yes, please describe the nature and relationship of the other person/people who have died:
_____
_____
_____
_____

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Has your child received any professional support (school counselor, psychologist, therapist, etc.)?
If so, for how long? Are they still receiving this support? _____
_____

Is there anyone that is not allowed to visit or pick up the camper? _____
_____

Camper's T-Shirt Size:

Children: Small (6-8) ___ Medium (10-12) ___ Large (14-16) ___

Adult: Small ___ Medium ___ Large ___ X-Large ___

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MEDICAL INSURANCE INFORMATION:

This camper is covered by family medical/hospital insurance ____yes ___no

_____ _____
Insurance Company Policy Number/Group Number

_____ _____
Subscriber Insurance Company Phone Number

Name of Primary Physician: _____ Phone number: _____
Name of Dentist: _____ Phone Number: _____
Name of Orthodontist (if applicable): _____ Phone Number: _____

Allergies:

___NO known allergies
___ Allergic to insect stings ___ Camper carries an Epi-Pen
___ Allergic to these medications:
Name of the medicine and reaction when medicine was taken: _____
_____

____Food Allergies
Name of the food and reaction when food was eaten: _____
_____
_____

Diet and Nutrition:

____ This camper eats a regular diet ____ This camper eats a regular vegetarian diet
____ This camper is restricted from eating the following: _____
_____

RESTRICTIONS:

____ No known restrictions related to camp activities/programs
____ This camper is restricted from the following activities/programs: _____
_____

DATE (year) OF LAST IMMUNIZATION:

Diptheria, tetanus, pertussis (DTaP or TdaP) _____
Tetanus Booster _____
Mumps, Measles, Rubella (MMR) _____
Varicella (chicken pox) _____ or had chicken pox _____ (year)
Haemophilus Influenza (HIB) _____

If your camper has not been immunized, please sign agreeing to the following statement:
I understand and accept the risks to my child from not being fully immunized.

_____
Signature of parent or legal guardian

Camp STAR Application Name _____

Please pack enough medication to last the entire weekend at camp (Friday afternoon through Sunday afternoon). **Keep all medication in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and frequency of administration.** Please bring all medications in a Ziploc bag labeled with your child's name. Upon arrival at camp during check-in we will update any changes to medications.

___ This camper will not take any daily medication while attending camp
___ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and /or improve their health. This includes vitamins and natural remedies.

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			___Breakfast ___Lunch ___Dinner ___Bedtime ___Other time		
			___Breakfast ___Lunch ___Dinner ___Bedtime ___ Other time		
			___Breakfast ___Lunch ___Dinner ___Bedtime ___Other		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper SHOULD NOT be given.**

Acetaminophen (Tylenol)

Ibuprofen (Advil, Motrin)

Guaifenesin cough syrup (Robitussin DM)

Generic cough drops

Antibiotic cream

Antihistamine/allergy medicine

Aloe

Calamine Lotion

Sore throat spray

Kaopectate or Pepto-Bismol

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Does your child have any disabilities? If yes, please explain.

_____
_____
_____
_____

Does your child have any behavorial challenges? If yes, please explain.

_____
_____
_____
_____

GENERAL HEALTH HISTORY *Check "Yes" or "No" for each statement.*

Has/does the camper:

1. Ever been hospitalized? ……..…… ___Yes ___ No
2. Ever had surgery? ……..… ___ Yes ___ No
3. Have recurrent/chronic illnesses? ……..… ___ Yes ___No
4. Had a recent infectious disease? ……..... ___ Yes ___No
5. Had a recent injury? ……..…..... ___Yes ___No
6. Had asthma/wheezing/shortness of breath? ….……... ___Yes ___No
7. Have diabetes? ……..……..… ___ Yes ___ No
8. Had seizures? ……..… ___ Yes ___ No
9. Had headaches? ……..… ___ Yes ___ No
10. Wear glasses, contacts or protective eyewear? ……..… ___ Yes ___ No
11. Had fainting or dizziness? ……..…… ___ Yes ___ No
12. Passed out/had chest pains during exercise? ……. ___ Yes ___ No
13. Had monoucleosis (mono) during the past 12 months? ___ Yes ___ No
14. Have a history of bedwetting? …….. ___ Yes ___ No
15. Have problems with diarrhea/constipation? ……. ___ Yes ___ No
16. Have problems falling asleep/sleepwalking? …… ___ Yes ___ No
17. Have any bleeding disorders? …… ___ Yes ___ No

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Please explain any "Yes" answers in the space below, noting the number of the questions. The camp may contacy you for additional information.

_____
_____
_____
_____

MENTAL,EMOTIONAL AND SOCIAL HEALTH: *Check "Yes"or "No' for each statement.*
Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit disorder with hyperactivity (ADHD)? ___ Yes ___ No
2. Ever been treated for emotional issues? ___ Yes ___ No
3. Ever been treated for behavorial difficulties? ___ Yes ___ No
4. During the past 12 months, been seen by a professional to address mental or emotional health concerns? ___ Yes ___ No
5. Ever been treated or diagnosed as having an eating disorder? ___ Yes ___ No

Please explain any "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

_____
_____
_____
_____

What have we forgotten to ask? *Please provide in the space below any additional information about the camper's helth or well-being that you think is important or that may affect the camper's ability to fully participate in the camp program. Attach addirional information if needed.*

_____
_____
_____
_____
_____
_____
_____
_____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurently reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permissin to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permssion to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's heakth status.

_____

Signature of Parent/Guardian Date

_____ Relationship to the camper

Indemnifying Release

In consideration of the admission of this camper to Camp STAR, I hereby waive any and all claims, liability or demands, which I may hereafter acquire against STAR Children's Bereavement Services or Bay Cliff Health Camp, a corporation, and against any and all of their officers, directors, and staff arising from or alleged to have arisen from the treatment, care, transportation, and entertainment of said camper while at said camp in Big Bay, Michigan, and I do jointly and severally hereby idemnify STAR Children's Bereavement Services and Bay Cliff Health Camp and their officers, directors and staff against and agree to hold them safe and harmless from any and all claims, demands, liabilty, cost and expense by or to any person or persons whatsoever arisinf or occuring aforesaid.

IN WITNESS WHEREOF we have hereunto executed these presents this _____day of _____,20__

Signed _____ Witness _____

Permission is hereby given for the use of photographs of the camper applicant for promotion and education about Camp STAR by STAR Children's Bereavement Services and Bay Cliff Health Camp.

Signed _____ Date _____

Application Due Friday, July 13

Please mail completed application to:

Camp STAR
STAR Children's Bereavement Services
PO Box 878
Marquette, MI 49855