CAMP STAR
SHARING TOGETHER & REMEMBERING

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: _____ Sex: _____

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 it happened, 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:
_____
_____

Camp STAR Application Name: _____

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

Demographic Info: Camp STAR is able to be provided free of cost to all of our families. However, we are funded by Grants, Community Partners, and individual donors. Some of these funding sources request the demographics of whom we serve. All information will be kept private and never associated with any identifying information of your family.

Age of Camper: _____ Zip Code of Residence:_____
Race:_____ Average Annual Income:_____

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 indemnify 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, liability, cost and expense by or to any person or persons whatsoever arising or occurring aforesaid.

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

Signed _____ Witness _____

Photo Release

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 _____

Camp STAR Camper Health History Form

Camper's Full Name: _____ Date of Birth: _____

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

Physician Information:

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/bites ___ Camper carries an Epi-Pen

___ Allergic to these medications: (Name of the medicine and reaction) _____

_____

_____

Food Allergies:

List food allergies and reaction: _____

_____

Diet and Nutrition:

____ This camper eats a regular diet ____ This camper eats a regular vegetarian diet

____ This camper is restricted from eating the following: _____

_____

Immunizations: (Year of last immunization)

Diphtheria, tetanus, pertussis (DTaP or TdaP) _____

Tetanus Booster _____

Mumps, Measles, Rubella (MMR) _____

Varicella (chicken pox) _____ or had chicken pox _____ (year)

Haemophilus Influenzae (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 _____

Medication Information:

___ This camper will not take any medication while attending camp

___ This camper will take the following medication(s) while at camp:

"Medication" is any substance taken to maintain and/or improve health including vitamins and natural remedies. Please list all over-the-counter and prescription drugs taken regularly and on an as needed basis. Don't forget to include any rescue medications such as inhalers or epi-pens. If more room is needed, attach additional sheet.

Name of Med	Reason for taking	Amount or dose given	Time of day taken/frequency	Route (oral, subq)	Comments

***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, you will have the chance to update any changes to medications.

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)
Guaifenesin cough syrup (Robitussin DM)
Antibiotic cream
Aloe
Sore throat spray
Ibuprofen (Advil, Motrin)
Generic cough drops
Antihistamine/allergy medicine
Calamine Lotion
Kaopectate or Pepto-Bismol

I give permission for the above medications be administered to my child by a health care professional on an as needed basis.

_____

Signature of parent/guardian

Camp STAR Application Name _____

Activity Restrictions:

____ No known restrictions related to camp activities/programs

____ This camper is restricted from the following activities/programs (include accommodations):

_____

_____

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

_____

_____

_____

Does your child have any behavioral 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 mononucleosis (mono) in 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
18. Other medical condition…….. ___ 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.

_____

_____

_____

Camp STAR Application Name _____

MENTAL,EMOTIONAL AND SOCIAL HEALTH *Check "Yes"or "No" for each statement.*

Has the camper:

1. Ever been treated for ADD or ADHD?..... ___ Yes ___ No
2. Ever been treated for emotional issues?.....___ Yes ___ No
3. Ever been treated for behavioral 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 health or well-being that you think is important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

_____
_____
_____
_____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately 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 permission 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 permission 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 health status.

_____

Signature of Parent/Guardian Date

Relationship to the camper: _____

Please mail completed application to: Camp STAR, PO Box 878, Marquette, MI 49855

Or scan and email to: upcampstar@gmail.com