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: ___________
Camper's T-Shirt size: Children: ___S(6-8) ___M(10-12) ___L(14-16) Adult: ___S ___M ___L ___XL

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: ____________________

Is there anyone that is **NOT ALLOWED** to visit or pick up the camper?
____
____

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?
____
____
____
____

Camp STAR Application Camper Name: ___________________________

Have there been multiple deaths of loved ones experienced by the child? Please check one of the following: ___ Yes ___No If yes, please describe the nature and relationship of the other person/people who have died:

____

____

____

____

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

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DEMOGRAPHIC INFO: Camp STAR is able to be provided free of cost to all of our families. 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. Demographic information will not exclude your child from camp.

Age of Camper: ____ Zip Code of Residence: _______Race: ________Average Annual Income: ________

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: ____

____

____

Camp STAR Application Camper Name: ____________________

DIET AND NUTRITION:

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

____ This camper is restricted from eating the following: ______________________________________

____

DATE (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 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: ____

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. Medicine will be stored and administered in the Nurse's Cottage during the duration of camp. Upon arrival at camp check-in, we will update any changes to medications.

___Camper will not take any daily medication while attending camp

___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		

Camp STAR Application Camper Name: ____________________

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. **Select those the camper SHOULD NOT be given.**

___Acetaminophen (Tylenol) ___Ibuprofen (Advil, Motrin) ___Generic cough drops

___Antibiotic cream ___Antihistamine/allergy medicine ___Aloe

___Calamine Lotion ___Kao pectate or Pepto-Bismol ___Sore throat spray

___Guaifenesin cough syrup (Robitussin DM)

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

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 Camper Name: ____________________

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

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

Does your child have any behavioral challenges? If yes, please explain:
____
____
____
____

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 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? *In the space below, please provide 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.*
____
____
____
____
____
____
____
____

Camp STAR Application Camper Name: ____________________

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

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 _______________________________

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 _________________________________

Please mail completed application to:

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

-or-

Email application to: upcampstar@gmail.com

Questions can be sent to upcampstar@gmail.com or call/text 906-250-2489