Family Application

Pre-registration is required. Please complete and submit the registration form by September 9, 2019.

The Eva's Hands Project is proud to be sponsoring and delivering Camp Eva 2019. Camp Eva is a half-day camp for children who are 5 to 12 years old and have experienced the death of a significant person or persons in their lives. Camp Eva provides a structured and supportive environment for children to openly share their feelings and memories of their loved ones. The children will be assigned to an adult who will guide them through the camp. Camp Eva will offer activities and times of sharing which will allow the children to take home new and healthy ways of coping with their feelings and loss. It is the goal of Camp Eva to provide a safe place for expression of feelings through fun and age appropriate activities.

There is no cost to families for the camp. There will be an one-hour parent workshop offered during the camp to better help parents and family understand how children grieve. This workshop will be delivered by Jessica Curd, Our Hospice of South Central Indiana.

Please complete the following application in full. There will be a follow up contact and family meeting with the Our Hospice as needed to ensure Camp Eva is a good fit for each child. Please return the completed applications to , Jessica Curd, Our Hospice of South Central Indiana, Inc., 2626 E. 17th Street, Columbus, IN 47201. Please contact Jessica Curd by email at jcurd@crh.org with any questions or call 812-314-8044.

We look forward to meeting you and your child!

Sincerely,

Jessica Curd
Our Hospice of South Central Indiana, Inc.

Child's Information:

Name: ____ Nickname: ______________________________________

School grade as of August 2019: __________ Age: _______ Birth Date: _______________________________

School Attends: ____

Gender: _____ Female _____ Male

Has this child attended any other grief camp or support group? _____ Yes _____ No

Please circle your child's T-shirt size : Youth: XS S M L XL Adult: XS S M L XL

Parent/Guardian Information:

Parent/Guardian Name: ____

Relationship: ____

Address: ____

Home Phone: ________________ Cell Phone: ________________ Work Phone: __________________________

Email: ____

Emergency Contact: (preferably other than that listed above)

Emergency Contact Name: ____

Relationship: ____

Address: ____

Home Phone: _______________ Cell Phone: _______________ Work Phone: ___________________________

Bereavement History:

Please include as much information as possible and add extra pages if necessary.

Name of the person who died: ____ Date of Death: ___________

Relationship of this person to the child: ____

Cause of death? ____

How old was the child at time of the death? ____

Where did the death occur? ____

Was the child present at the time of the death? ____

Did the child attend funeral or memorial services? ____

Bereavement History continued

How did your child react to the death and experiences of the services? ________________________________

____

____

____

Has your child received counseling in any form for grief? _____ Yes _____ No

If yes, please provide the name of the counselor and duration of services: ____________________________

____

What signs of grief have you seen from your child? ____

____

____

Have you noticed any behavior changes in your child since the death? ________________________________

____

Any other significant life changes for your child? (re-marriage, relocation, divorce, illness, loss of a pet, etc.)

____

____

How would you like your child to benefit from Camp Eva? ____

____

Do you give permission for your child to participate in pet therapy with a trained dog and approved volunteer? ____Yes ____No

Child's Medical History:

Please answer the following questions in full so that necessary preparations can be made as needed to best serve your child during the camp.

Are your child's immunizations up to date? _____ Yes _____ No

Please attach a copy of the immunization records.

Any recent surgery/hospitalizations? ____

Any significant illness within last year? ____

Are there dietary restrictions/needs? ____

Food allergies and reaction to exposure? ____

Medication allergies and reaction to exposure? ____

Insect Sting allergies and reaction to exposure? ____

Other allergies or medical concerns? ____

Medical History continued:

Does your child have any medical or physical limitations? Please describe: ______________________________

____

Any behavior concerns? ____

Any emotional concerns? ____

Does your child need assistance with toileting or personal hygiene? ____________________________________

____

Weight: ______________________________ Height: ______________________________

Primary Care Physician: ____

Phone Number: ____

Please provide any other medical or physical needs information that the camp staff should know:

____

____

Please list all medications and dosages: (Camp staff will not be able to administer any medications)

____

____

Does your child have health insurance?: _____ Yes _____ No

Insurance carrier: ___________________________ Policy Holder: ______________________________________

Policy Number: _____________________________ Group/Member ID: ________________________________

All of the application information will be reviewed by Our Hospice of South Central Indiana, Inc. and a nurse who is volunteering during the camp.

Parent/ Guardian Signature: ____ Date: _________________

Our Hospice Signature: ____Date: _________________

Please complete and submit registration forms by September 9, 2019.