



*Jim Arnold*

**Camp Rainbow of Hope  
Camper Application Form**

Child's Name: \_\_\_\_\_ (nickname) \_\_\_\_\_

School Grade as of Fall 2010 \_\_\_\_ Age: \_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: Female: \_\_\_\_ Male: \_\_\_\_

School Attended: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: \_\_\_\_\_ e-mail Address: \_\_\_\_\_

Name of Child's Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Please list any food allergies, dietary restrictions (physician recommended/religious, etc.):

Please list your child's religious affiliation (if any): \_\_\_\_\_

Has your child ever spent the night away from home? \_\_\_\_ Yes \_\_\_\_ No

Does your child have any sleep problems (i.e. sleepwalking, bedwetting, nightmares)?

Please list any additional information (problems with eating, getting along with friends/peers or family members, school attendance, physical limitations, etc.):

Child's T-shirt Size:

Children \_\_\_\_ S (6-8) \_\_\_\_ M (10-12) \_\_\_\_ L (14-16)

Adult \_\_\_\_ S \_\_\_\_ M \_\_\_\_ L \_\_\_\_ XL

Please list any sports/interests/hobbies that your child has:

**Camp Rainbow of Hope  
Bereavement History**

Please include as many details as possible when answering the following questions.  
Attach extra pages if necessary.

1. Who was the person who died (name): \_\_\_\_\_
2. How was the person related to the child? \_\_\_\_\_
3. What was the cause of death? \_\_\_\_\_
4. When did the death occur (date)? \_\_\_\_\_
5. Age of your child when the death occurred: \_\_\_\_\_
6. Where did this person die? Home\_\_\_\_Hospital\_\_\_\_ Explain:
  
7. Was the child present at the time of death? Explain circumstances.
  
8. Did the child attend the funeral/memorial service? If yes, what was your child's reaction to/or comments about the service?
  
9. Has your child received any professional support (i.e. school counselor, peer support group, psychologist, psychiatrist, pastoral counselor)?  
  
\_\_\_\_ Yes \_\_\_\_ No (if no, skip to #10)  
  
If yes, is support currently being provided?  
\_\_\_\_ Yes \_\_\_\_ No  
  
If counseling is no longer in progress, how long was the period of support provided?
10. Please explain how your child indicates that he/she is grieving.
  
11. Have there been multiple deaths of loved ones experienced by this child? If yes, please describe the nature of death and the child's relationship to the other person who died.
  
12. Have there been any other changes/stresses in your child's life (i.e. divorce, remarriage, relocation, illness)?

## Camp Rainbow of Hope Health History Form

Camper's Name: \_\_\_\_\_  
(Last) (First)

Home Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Child's Height: \_\_\_\_\_ Child's Weight: \_\_\_\_\_

Parent/Guardian \_\_\_\_\_  
(Last) (First)

Parent/Guardians Phone (Day): \_\_\_\_\_ Evening: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Information about your child's health history is to insure his/her safe stay at Camp. It will not have any bearing on whether your child is chosen to attend. Child will not be allowed to come to camp unless he/she has all vaccinations and/or booster. **Give date (month and year) of last vaccination for each listed:**

Polio \_\_\_\_\_ Diphtheria \_\_\_\_\_ Rubella \_\_\_\_\_ Mumps \_\_\_\_\_ Tetanus \_\_\_\_\_ Measles \_\_\_\_\_

Health History (check those that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Attention Deficit Disorder (ADD) | <input type="checkbox"/> Asthma                        |
| <input type="checkbox"/> Constipation/Diarrhea            | <input type="checkbox"/> Convulsions/Seizures          |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Emotional Problems            |
| <input type="checkbox"/> Fainting                         | <input type="checkbox"/> Severe Reaction to poison ivy |
| <input type="checkbox"/> Hearing Impairment               | <input type="checkbox"/> Heart Disease                 |
| <input type="checkbox"/> Menstrual Cramps                 | <input type="checkbox"/> Hepatitis                     |
| <input type="checkbox"/> Nightmares                       | <input type="checkbox"/> Kidney Disease                |
| <input type="checkbox"/> Hay Fever                        | <input type="checkbox"/> Frequent ear infections       |
| <input type="checkbox"/> Wears Contact Lenses/glasses     | <input type="checkbox"/> Bleeding/Clotting Disorder    |
| <input type="checkbox"/> Developmentally Delayed          | <input type="checkbox"/> Other (please explain)        |

Severe reaction to insect or bee stings? Yes or No (circle One) If yes, is medication provided?

\_\_\_\_\_

Please explain any information we need to know to care safely for your child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

Child's Health Care Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Plan Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Other Significant Allergies: \_\_\_\_\_

Are there any activities your child may not be able to participate in while at camp?  
\_\_\_\_ Yes \_\_\_\_ No (If Yes, please explain):

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

The Health History is correct to my knowledge. The person herein described has permission to engage in all prescribed camp activities except as noted. I give my permission, in the case of any emergency that requires hospital admittance or treatment, for the Camp Rainbow of Hope staff and/or emergency medical staff to care for my child and receive discharge information from the hospital until I can be contacted. Also, I give my permission for my child's picture to be taken and used for publicity purposes only.

\_\_\_\_\_  
Signature of Parent/Guardian Date: \_\_\_\_\_

***Please Return this Application to:***

***Debbie Bishop, Executive Director  
Friends of Oswego County Hospice  
P.O. Box 102  
Oswego, NY 13126***