



Friends of
Oswego County
Hospice, Inc.

**Camp Rainbow of Hope
Camper Application Form**

Child's Name: _____ (nickname) _____

School Grade as of Fall 2008 _____ 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:

Please enclose a photo of your child.

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: _____