PATHWAYS CENTER for GRIEF & LOSS

January 2024

Dear Parent/Guardian,

Thank you for your interest in *Camp Chimaqua*, an overnight bereavement camp, offered through Hospice & Community Care's Pathways Center for Grief & Loss. The camp is held on **May 17-19, 2024** at Gretna Glen Camp & Retreat Center. Registration will begin at 5:00 p.m. on Friday, May 17.

The enclosed application provides you the opportunity to share information needed to ensure your child's camp experience is helpful and rewarding. Please answer all questions that apply and return the packet promptly in the enclosed envelope. If you have more than one child attending, a separate packet must be completed for each child. We will call to arrange an in-person interview with you and your child(ren) once we receive the application(s).

Camp applications must be received by Friday, April 19, 2024 so there is enough time to arrange an interview.

Thanks to the generosity of the Hospice Circle of Friends, the only cost is a $25 registration fee per camper. Please make your check payable to *Hospice & Community Care* and include it with the returned application. Financial assistance is available if needed. **Registration fee is non-refundable after May 10, 2024.**

Again, thank you for your interest in Camp Chimaqua. Please remember that space is limited and reservations are made on a *first-come, first-served* basis. If you have additional questions about the camp or application packet, please call me at the Pathways Center for Grief & Loss, (717) 391-2413.

We look forward to hearing from you!

Diane Kulas, MSW, LSW

Diane Kulas, MSW, LSW
Children's Services Coordinator

Enclosures

Street Address: 4075 Old Harrisburg Pike • Mount Joy, PA 17552 • Mailing Address: P.O. Box 4125 • Lancaster, PA 17604-4125
Phone: (717) 391-2413 • Fax (717) 735-9667 • www.pathwaysthroughgrief.org • E-mail: pathways@hospicecommunity.org
HOSPICE & COMMUNITY CARE

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CAMP CHIMAQUA APPLICATION

Date application is completed: _____

Camper's name: _____
(first) (middle) (last)

Home address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Age: _____ Sex: _____

Current school grade: _____ School attending: _____

Parent/Guardian's name: _____

Day phone: _____ Evening phone: _____

Email address: _____

How did you hear about Camp Chimaqua? _____

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

Have you talked to your child about attending Camp Chimaqua? ❑ Yes ❑ No

What, if any, concerns do you have about your child going to camp? _____

_____

Child's T-Shirt Size: Child: S _____ M _____ L _____

Adult: S _____ M _____ L _____ XL _____

FOR OFFICE USE

Chart # _____ CKT Assessment: _____
Date

Application received: _____ Approved: _____
Date Date

Check received: _____ Not Approved: _____
Date Date

Camper's Name: _____ **Record #:** _____

In case of emergency and parent/guardian cannot be reached, contact:

Name:_____

Day phone:_____ Evening phone: _____

Name:_____

Day phone:_____ Evening phone: _____

Authorization for Release

For your child's safety, Camp Chimaqua staff and volunteers have permission, before releasing your child, to ask anyone to present a photo ID (i.e. driver's license). We will not release your child unless proper identification is given. Please list persons (including yourself) authorized to pick up your child.

Name	Phone	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sunday Lunch

On Sunday, we invite families (parents/guardians and siblings of the camper) to join us for a closing ceremony and lunch.

- Please indicate the number of people you anticipate joining us for lunch – **DO NOT** include your camper in this total:_____
- Please indicate dietary restrictions for anyone joining for lunch: _____

_____

Parent/Guardian Signature: _____ **Date:** _____

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CAMP CHIMAQUA
BEREAVEMENT HISTORY

Camper's Name: _____ **Record #:** _____

Name of person(s) who died: _____

Age of deceased at time of death: _____

Relationship of your child to deceased: _____

Date and cause of death: _____

Was the deceased cared for by Hospice & Community Care? ❑ Yes ❑ No

Was the death anticipated? ❑ Yes ❑ No

Does your child know the cause of death? ❑ Yes ❑ No

Comments: _____

_____

Was your child present at the time of death? ❑ Yes ❑ No

Comments: _____

_____

Did your child see the deceased after the death? ❑ Yes ❑ No

Did your child attend the funeral/memorial service? ❑ Yes ❑ No

If yes, what were your child's reactions/comments to the service? _____

_____

Do you and your child talk about the deceased? ❑ Yes ❑ No

Did you and/or your family receive counseling? ❑ Yes ❑ No

What behavior(s) does your child exhibit that indicate your child is still grieving? _____

_____

Has your child said or done anything recently that concerns you? ❑ Yes ❑ No

If so, please describe: _____

_____

Does your child have difficulty sleeping or crying at night? ❑ Yes ❑ No

If so, how have you handled this? _____

_____

Has your child experienced any other deaths? ❑ Yes ❑ No

Comments: _____

_____

Have there been any other changes/stressors in your child's life (i.e. divorce, relocation, illness)?

❑ Yes ❑ No

Comments: _____

_____

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CAMP CHIMAQUA
BEREAVEMENT HISTORY

Camper's Name: _____ **Record #:** _____

Has your child ever:

Attended day camp?	❑ Yes	❑ No
Attended overnight camp?	❑ Yes	❑ No

Does your child enjoy:

Music?	❑ Yes	❑ No
Outdoor activities?	❑ Yes	❑ No
Arts and crafts?	❑ Yes	❑ No
Creative writing?	❑ Yes	❑ No
Reading?	❑ Yes	❑ No
Sports/physical activity?	❑ Yes	❑ No

If yes, list the sport(s)/activities: _____

_____

What is your child's favorite color? _____

What is your child's favorite TV show/movie? _____

What is your child's favorite sports team? _____

What is your child's favorite animal? _____

Please list other things your child enjoys doing (hobbies, interests, etc). _____

_____

_____

Is there anything we should know to better accommodate your child? _____

_____

Parent/Guardian Signature: _____ **Date:** _____

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CAMP CHIMAQUA
CAMPER MEDICATION INFORMATION

Camper's Name: _____ **Record #:** _____

Does your child have any of the following:			If yes, please explain:
Physical limitations	❑ Yes	❑ No	_____
Hearing impairment	❑ Yes	❑ No	_____
Ear infections	❑ Yes	❑ No	_____
Nose bleeds	❑ Yes	❑ No	_____
Emotional problems	❑ Yes	❑ No	_____
Bed wetting	❑ Yes	❑ No	_____
Diabetes	❑ Yes	❑ No	_____
Eating disorder	❑ Yes	❑ No	_____
Dietary restrictions	❑ Yes	❑ No	_____
Constipation/diarrhea	❑ Yes	❑ No	_____
Asthma	❑ Yes	❑ No	_____
Breathing problems	❑ Yes	❑ No	_____
ADD/ADHD	❑ Yes	❑ No	_____
Epilepsy/seizures	❑ Yes	❑ No	_____
Sickle Cell Anemia	❑ Yes	❑ No	_____
Wears contact lenses/glasses	❑ Yes	❑ No	_____
Allergies	❑ Yes	❑ No	_____

Does your child have any dietary restrictions? ❑ Yes ❑ No

Please specify: _____

Other illnesses or medical conditions, past or present, which are significant to mention? ❑ Yes ❑ No

Please specify: _____

Will your child be taking medication at camp? If yes, please specify below. ❑ Yes ❑ No

Medication/Dosage	For what?	Time(s) to be given
1.		
2.		
3.		
4.		
5.		
6.		

Camper's Name: _____ **Record #:** _____

Method of administration (to be taken with water, milk, food, etc.): _____

_____

List any reasons for not giving medication at the prescribed time (vomiting, fever, drowsiness, convulsions): _____

_____

Immunizations

My child has received all necessary immunizations required for school enrollment/attendance and these immunizations are up to date. ❑ Yes ❑ No

Please provide the month/year of last tetanus shot (DTaP or Tdap):

this information is required: _____ (month) _____ (year)

If your child has not been fully immunized, please explain: _____

_____

_____

❑ If there is any additional information that the Camp Chimaqua staff should know concerning your child, please check this box and attach a separate sheet to this form.

Permission is granted for my child to participate in all camp activities (which are more fully described in camp materials) except as limited or excluded in the Health History Form. I am not aware of any other health reason(s) (other than those documented) that would preclude my child from participating in camp activities.

Parent/Guardian Signature: _____ **Date:** _____

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CAMP CHIMAQUA
SPECIAL DIET REQUESTS FOR GRETNA GLEN

Gretna Glen has an on-line process to submit dietary issues, such as dietary allergies, intolerances or other dietary needs. If your camper has any dietary restrictions or issues, please complete the following information and a Coping Kids & Teens staff member will complete the on-line form after your child has been approved to attend camp. This on-line form is sent directly to Gretna Glen's Hospitality Manager and Food Service Staff. If the Hospitality Manager has any questions, he/she will contact you directly.

Food Restrictions and Allergies – Special Diet Request Form

Camper's First Name: _____

Camper's Last Name: _____

Parent/Guardian email address: _____

Parent/Guardian phone number: _____

Group Name: **Camp Chimaqua/Pathways Center for Grief & Loss**

Event Dates: **May 17-19, 2024**

Food ALLERGIES: Please check all that apply:

- ❑ Gluten allergy
- ❑ Dietary allergy
- ❑ Peanut allergy
- ❑ Tree nut allergy
- ❑ Egg allergy
- ❑ Shellfish allergy

Food INTOLERACES/DIETARY PREFERENCES: Please check all that apply:

- ❑ Gluten free
- ❑ Dairy free
- ❑ Lactose intolerant
- ❑ Vegetarian
- ❑ Vegan

Other Information:

_____

_____

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CAMP CHIMAQUA
PERMISSION TO ADMINISTER MEDICATIONS

To be completed by parent or guardian.

Camper's Name:_____ **Birth Date:** _____
Record #: _____

Camp Chimaqua is staffed by a registered nurse. The nurse may not diagnose or prescribe medication or treatment.

In order to relieve your child's distress when ill, the Camp Health Professional needs your written permission to administer the following over-the-counter medications. Medications will be administered only when deemed necessary by camp health personnel and only at recommended weight-age dosages as listed on the product label.

Please place your **initials** next to whichever over-the-counter medications you are authorizing. If you do not authorize medications supplied by camp, please initial the space provided for "NO" and indicate the substitute that you will send to camp for your child.

1. **For pain, fever, cramps, headache – INITIAL ONLY ONE.**
   - _____ No preference. Camp has my permission to administer either Acetaminophen (Generic substitute for Tylenol® or Ibuprofen (Generic substitute for Advil®).
   - _____ Camp has my permission to administer only Acetaminophen (Generic substitute for Tylenol®).
   - _____ Camp has my permission to administer only Ibuprofen (Generic substitute for Advil®).
   - _____ NO, I will send in_____

2. **For allergic reaction to insect bite/sting - Benadryl® or generic Diphenhydramine**
   _____ YES, camp has my permission to administer _____ NO, I will send _____
   Initials *Initials*

3. **To relieve itching (poison ivy/insect bite/rash) – anti-itch topical (Benadryl® spray/Caladryl® lotion)**
   _____ YES, camp has my permission to administer _____ NO, I will send _____
   Initials *Initials*

4. **To cleanse eyes/eyewash – Hypotears® Saline Solution**
   _____ YES, camp has my permission to administer _____ NO, I will send _____
   Initials *Initials*

5. **To prevent ticks – insect repellent with Deet®**
   _____ YES, camp has my permission to administer _____ NO, I will send _____
   Initials *Initials*

If you send an alternate over-the-counter remedy or prescription medication, it must be kept by the camp nurse. All medications sent from home must be in the **original pharmacy container**, and if prescription, **prescribed in the name of the child. ALL medications must be properly labeled with the child's name, and accompanied by instructions, signed by parent/guardian, indicating dosage, and time(s) to be administered.**

Camper's Name: _____ **Record #:** _____

For bee/insect stings, our protocol is to remove the stinger when possible, apply ice at site of bite/sting, and observe child. Benadryl® will be administered if deemed necessary by the nurse, or if there is a history of reaction as indicated below. For a severe reaction, an Epi-Pen® will be given.

- ❑ No history – has never been stung
- ❑ Stung and had an allergic reaction
- ❑ Stung but had no allergic reaction
- ❑ Check here if anyone in your child's immediate family has experienced a severe allergic reaction to bee/insect stings
- ❑ Epi-Pen® being sent by parent/guardian

Parent/Guardian Signature: _____ **Date:** _____

Adapted with permission by Camp Erin, The Moyer Foundation,
Penn Home Care & Hospice Services, Wissahickon Hospice

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CAMP CHIMAQUA
PARENT/LEGAL GUARDIAN CONSENT FOR PARTICIPATION

Camper's Name:_____ **Birth Date:** _____

Record #_____

Hospice & Community Care considers the information you provide regarding your child to be confidential. It will only be made available, to the extent necessary, to appropriate camp staff, volunteers, and Pathways Center for Grief & Loss staff who will be working with your child.

I understand that the registration fee is non-refundable after **May 10, 2024.**

I understand and agree that if my child appears ill prior to attending camp, I will not send my child to camp.

I confirm that all information provided is, to the best of my knowledge, accurate and complete.

I understand that, in the event of a medical emergency I will be immediately contacted. Hospice & Community Care on-site medical staff (registered nurse, CPR certified staff and/or physician) will initiate immediate medical, and if necessary, life sustaining measures and will contact, if needed, emergency medical personnel for assistance.

I further understand that my preferred physician/medical facility will be contacted and utilized whenever possible. If I am unable to be reached and medical circumstances require immediate transport for care, this will be initiated and emergency medical personnel will provide for the immediate needs of my child and determine the transport location.

Preferred Physician Name: _____ Phone #: _____

Hospital: _____

Medical Insurance: _____ Phone #: _____

Policy Holder's Name: _____

Identification #: _____

Policy/Group #: _____

Employer: _____

I hereby release and discharge Hospice & Community Care, it's employees or volunteers from any legal responsibility and/or liability for any personal injuries or illnesses, either physical or emotional; or injury to property, real or personal, whether that injury is due to negligence or any other fault, which may occur while my child attends Camp Chimaqua. I have read the information on the Pathways Center for Grief & Loss. I have received Hospice & Community Care's *Notice of Privacy Practices*. I understand the Camp Chimaqua program provided by the Pathways Center for Grief & Loss, have had the opportunity to ask questions and have received acceptable and understandable answers. I understand the services that are available through the Pathways Center for Grief & Loss, realize its limitations and benefits, and voluntarily choose to participate in services for myself and my child.

_____ _____

Parent/Guardian Name (please print) **Parent/Guardian Signature**

_____ _____

Child's Name (please print) **Date**

HOSPICE & COMMUNITY CARE

PATHWAYS CENTER for GRIEF & LOSS

CAMP CHIMAQUA RELEASE FORM – For Minors

I hereby assign and release Hospice & Community Care all rights to the electronic image/film/ photography/DVD/sound recordings and written statements made by me, my child (if under 18 years old), and/or Hospice & Community Care, and I hereby authorize the use of same by Hospice & Community Care, and those acting with its permission, for the purpose of education, illustration, publications, social media or broadcast in connection with the work of Hospice & Community Care. I agree to receive emails of the above items for my personal memories.

I hereby assign and release Hospice & Community Care all rights to utilize **group** electronic image/film/photography/DVD/sound recordings and written statements made by me, my child, and/or Hospice & Community Care, and I hereby authorize the use of same by Hospice & Community Care, and those acting with its permission, for the purpose of education, illustration, publications, social media or broadcast in connection with the work of Hospice & Community Care. I understand these items could be shared with other participants families. I agree not to share any items sent to me via email on social media to protect the privacy of other participants.

Any disclosure of other patient-related information by Hospice & Community Care, whether written or verbal, requires separate authorization.

I understand that I have the right to request cessation of the production of the recordings, films, or other images by submitting a written request.

I certify that I am over 18 years old, or if not, that a parent/guardian has signed below.

I have read the foregoing release and authorization before affixing my signature and I warrant that I fully understand the contents thereof.

_____ I do not consent to Hospice & Community Care utilizing electronic image/film/ photography/DVD/sound recordings and written statements made by me or my child.

_____ _____

Print Name of Child
(Subject of image/quote/etc.)

Child's Date of Birth

_____ _____

Address of Child

City, State, Zip Code

_____ _____

Signature of Parent/Guardian or POA authorizing consent for child
(if client is under 18 years of age)

Date

_____

Witness Signature (HCC staff or adult)

For Office Use:

_____
Record Number (of client)