**Registration Form**

***When****: September 15, 2018****Where****: Red Top Mountain State Park, 50 Lodge Rd., Group Shelter #1, Acworth, Georgia 30102****Who:*** *Families who have experienced the loss of a loved one.****Cost:*** *$25 per family.* ***Scholarships available.***

**Registration Deadline: July 1, 2018**

**Family’s Information**

Family Last Name: Home Phone: Address:   
City: State: Zip:   
Adult #1 Name: Gender: \_\_\_\_ Age:\_\_\_\_ Date of Birth:

T-Shirt Size (circle one): **Adult:** Sm Md Lg XL 2X  
Adult #2 Name: Gender: \_\_\_\_ Age:\_\_\_\_ Date of Birth:

T-Shirt Size (circle one):  **Adult:** Sm Md Lg XL 2X  
Child #1 Name: Gender: \_\_\_\_ Age:\_\_\_\_ Date of Birth:

T-Shirt Size (circle one): **Youth:** Sm Md Lg **Adult:** Sm Md Lg XL 2X   
Child #2 Name: Gender: \_\_\_\_ Age:\_\_\_\_ Date of Birth:

T-Shirt Size (circle one): **Youth:** Sm Md Lg **Adult:** Sm Md Lg XL 2X   
Child #3 Name: Gender: \_\_\_\_ Age:\_\_\_\_ Date of Birth:   
T-Shirt #5 Size (circle one): **Youth:** Sm Md Lg  **Adult:** Sm Md Lg XL 2X

**Child’s Emotional Health**

Are any family members (attending camp) exhibiting ineffective coping skills or behaviors related to the loss of your loved one? Identify by name and circle concerns below.

|  |  |  |
| --- | --- | --- |
| **Camper Name:** | **Camper Name:** | **Camper Name:** |
| Night Terrors | Night Terrors | Night Terrors |
| Acting Out: Home or School | Acting Out: Home or School | Acting Out: Home or School |
| Cutting/Self Harm | Cutting/Self Harm | Cutting/Self Harm |
| Lying | Lying | Lying |
| Difficulty expressing emotions | Difficulty expressing emotions | Difficulty expressing emotions |
| Excessive Fears | Excessive Fears | Excessive Fears |
| Anger Management | Anger Management | Anger Management |
| Withdrawn | Withdrawn | Withdrawn |

Please indicate any other medical and/or emotional needs that any camper is experiencing that you feel we should know (i.e. ADHD, Sees psychologist/psychiatrist regularly, traumatic events, etc.)

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

**Loved One’s Information:**

Name: Date of Death:   
Cause of Death:   
Adult Camper #1 age at time of death: Relationship to deceased:   
Adult Camper #2 age at time of death: Relationship to deceased:   
Child Camper #1 age at time of death: Relationship to deceased:   
Child Camper #2 age at time of death: Relationship to deceased:   
Child Camper #3 age at time of death: Relationship to deceased:

**Parent/Guardian(s) Information:**

Father’s Name: Mother’s Name:

Home Phone: Home Phone:   
  
Business Phone: Business Phone:   
  
Parent/Guardian E-mail:

**Mobile Phone: Mobile Phone:**   
  
Name of Parent/Guardian(s) with whom child/children live(s):   
  
Relationship to child:   
  
**EMERGENCY CONTACT – Person to contact in case of emergency if parents cannot be reached:**  
Name: Day Phone:   
  
Relationship to child: Evening Phone: \_\_\_\_

I have read and understand the contents of this application.

Signature of Parent/Guardian Date

**Registration Information**:

All campers must have adequate health/accident insurance. **Mail completed registration form, copy of front and back of medical insurance card, along with $25 fee to:**

**WellStar Community Hospice**

**475 Dickson Avenue Marietta, GA 30066.**

**\*\*No camper will be allowed into camp without a completed registration form.** For more information, call 678-581-8380.

**Camp Tranquility Consent Form**



The following consent agreement must be signed by a parent or legal guardian of the minor child/children in order for the child/children to attend WellStar Bereavement Camp.

Your signature below indicates approval of the following:

1. In the event that my family, , participate at WellStar Bereavement Camp during the 2016 session, I hereby attest that this health history is correct so far as I know and the family/children named above have permission to engage in all prescribed camp activities except as noted. The staff of Camp Knoll and the WellStar Bereavement Camp exercise caution in the conduct of all camp activities; however, they do not assume responsibility for accidents, injury or illnesses suffered by its campers.   
     
   I further understand that serious accidents occasionally occur during Camp activities, and that participants in Camp activities occasionally sustain mortal or serious personal injuries and/or property damage as a consequence thereof. Knowing the risks of Camp activities, nevertheless, I hereby agree to assume those risks and to release and hold harmless all of the persons or entities mentioned above who (through negligence or carelessness) might otherwise be liable to my children or to me (or to my heirs or assigns) for damages.
2. WellStar Bereavement Camp accepts no responsibility for the loss, damage or theft of your family/children’s property.
3. If you have any health and accident insurance coverage, please list:  
     
   Name of insurance company: Phone:   
     
   Address: City: State: Zip:   
     
   Policy No: Medicaid No:
4. Notwithstanding Paragraph 1, I recognize and understand that WellStar Bereavement Camp is a charitable organization. My child and I are receiving all of the benefits of WellStar Bereavement Camp with minimal or no costs to us and recognize that WellStar Bereavement Camp is immune from suit under Georgia’s Charitable Immunity Doctrine.
5. In case of medical and/or surgical emergency, you authorize WellStar Bereavement Camp’s medical staff to render to your child or to arrange for your child to receive any X-rays, anesthetic, medical, dental, surgical diagnosis, treatment, and hospital care which is deemed advisable by and is to be rendered under, the supervision of any physician, dentist or surgeon licensed to practice in the State of Georgia. I also grant permission for a licensed nurse to administer over-the-counter medication, such as ibuprofen, acetaminophen, and antihistamine, as needed.
6. I acknowledge that reporters, photographers, videographers and other members of the media may attend WellStar Bereavement Camp in order to increase the awareness about WellStar Community Hospice and its programs. I grant permission for my family/children to be interviewed, photographed, and filmed by any member of the media at WellStar Bereavement Camp. I understand that WellStar Community Hospice is not responsible for the content of the media coverage and that my family/children will not be paid for any media work.
7. WellStar Community Hospice and its representatives have absolute permission to use my family/children’s image in a photograph or video or my child’s artwork that pertains to the lawful programs and activities of the Camp.
8. All information is correct so far as I know and the child being described has permission to engage in all prescribed Camp activities, except as noted by me and the examining physician.

Signature: Date:   
Print Name: Relationship to Camper:

All Campers’ Names who are attending Camp Tranquility :

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