



Dear Parent/Guardian:

Thank you for your interest in bringing your child to Camp Horizon, sponsored by Sacred Journey Hospice Foundation. We promise to make this a memorable experience for your child. Camp Horizon will be held Saturday, August 20 at Community Bible Church in Stockbridge. This one-day camp experience is open to any child age 6-16 who has experienced the loss of a loved one.

Camp check-in will be at 8:30 a.m. and will conclude at 5:00 p.m. Camp Horizon 2011 will have the following foci:

1. Providing peer support to bereaved children and teens dealing with the grief process
2. Teaching positive coping skills for future life challenges by learning about yourself and what has helped others
3. Rebuilding trust in the family through communication of feelings and sharing stories about the deceased and the impact of the deceased's death on individual family members.

Space is limited, so please return your completed application promptly. The deadline for application submission is **August 1, 2011**. In addition to the attached application, please provide a photo of your child as well as one of your child and the loved one they lost. Mail your completed application to:

Camp Horizon  
P. O. Box 789  
McDonough, GA 30253  
Fax (888) 478-1110

We look forward to making this fun and rewarding with activities guaranteed to both empower and entertain. There will be no cost to attend the camp but we request that any cancellations are made prior to August 15. If you would like more information about Camp Horizon, contact us at (888) 478-1110.

Sincerely,

Laura Turner  
President  
Sacred Journey Hospice Foundation



## 2011 Registration Form

In order to attend Camp Horizon, your child must be pre-registered. Registrations are made on a first-come, first-served basis. **Please complete a separate registration form for each child.** A confirmation letter will be sent to you to secure your child's registration. Return your completed registration form by mail to P. O. Box 789, McDonough, GA 30253 or fax to (888) 478-1110. **The deadline for registration is August 1, 2011.**

Child's First Name \_\_\_\_\_ Child's Last Name \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Relationship to the Child \_\_\_\_\_

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Alt. Phone \_\_\_\_\_

Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender  Male  Female

School \_\_\_\_\_ Grade in Sept. \_\_\_\_\_

Please list other family members and note if they are attending camp as well.

Names \_\_\_\_\_ Attending Camp?  Yes  No

\_\_\_\_\_ Attending Camp?  Yes  No

\_\_\_\_\_ Attending Camp?  Yes  No

T-Shirt Size Child: S \_\_\_ M \_\_\_ L \_\_\_ Adult: S \_\_\_ M \_\_\_ L \_\_\_ XL \_\_\_

**Information about the person who died:** *Please complete the following information as accurately as possible. This information is very helpful to the overall care of your child while at Camp Horizon.*

Name of Loved One \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Was your family a patient of Sacred Journey Hospice?     Yes     No

Date of Death \_\_\_\_/\_\_\_\_/\_\_\_\_    Age at Death \_\_\_\_

Cause of Death \_\_\_\_\_

What was this person's quality of life during the dying process (length of illness, etc.)? \_\_\_\_\_

\_\_\_\_\_

Was your loved one's death sudden and/or tragic? (please explain)

\_\_\_\_\_

\_\_\_\_\_

Please describe the relationship between your child and your loved one.

\_\_\_\_\_

\_\_\_\_\_

What was the reaction of the child?

\_\_\_\_\_

\_\_\_\_\_

What was your reaction? Was speaking to your child difficult?

\_\_\_\_\_

\_\_\_\_\_

How has the behavior or emotions of your child changed or not changed since the death?

\_\_\_\_\_

\_\_\_\_\_

Did your child attend the funeral or memorial service? What was their experience?

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What support does your child have? (family, friends, sports, school)

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Has your child experienced any other losses? What loss and when did they occur? (These include family, friends, moving, divorce, pets.)

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Is there anything else that we should know that would help us in the care of your child? \_\_\_\_\_

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**Counseling/ Mental Health Information:**

Has your child received counseling, psychological, or psychiatric treatment related to the death of your loved one? (If yes, please explain) \_\_\_\_\_

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If your child is seeing a mental health professional, did they approve your child attending Camp Horizon? \_\_\_\_ Yes \_\_\_\_ No

Has your child experienced any negative thoughts or behaviors recently?

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## Mental Health Waiver/Consent

As the parent/guardian of \_\_\_\_\_ (name of child) I give permission to Camp Horizon staff and designees to review sensitive information in the application for the purpose of giving my child high quality care on the day of camp. I understand that all information will be kept confidential and that all Camp Horizon staff and workers have signed an agreement to keep said information confidential. I am aware that Camp Horizon is not designed to provide individual or group therapy to my child. I understand that Camp Horizon is designed to offer support and psychoeducation related to grieving. I am aware that Camp Horizon will have licensed and non-licensed mental health professionals available at Camp Horizon for the purpose of offering support and teaching about grieving. I give permission for any mental health professional working with Camp Horizon to use their professional skills in the afore mentioned manner and to help my child should they become overly upset during the scheduled time frame of Camp Horizon. I understand that Camp Horizon is in no way a substitute for mental health treatment and that staff and mental health professionals participating in Camp Horizon are not charged with the duty of assessing or treating my child on the day of camp. I release all Camp Horizon staff, volunteers, mental health professionals, and all others from any ill affects produced by camp activities. I understand that should my child experience overly negative thoughts and/or emotions during camp I will be notified immediately using the contact information provided. If I can not be reached, I understand my child will be closely supervised or medical attention may be sought if behaviors are unmanageable and harmful to self or others.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Medical Information:**

Previous or Significant Medical Conditions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the child have any allergies?

Drug Allergies: \_\_\_\_ Yes \_\_\_\_ No If yes, what \_\_\_\_\_

Food Allergies: \_\_\_\_ Yes \_\_\_\_ No If yes, what \_\_\_\_\_

Other Allergies: \_\_\_\_ Yes \_\_\_\_ No If yes, what \_\_\_\_\_

Medications: We will distribute medications that are necessary for your child. All medications must be brought in an original prescription bottle with the child’s name, accurate dosage, and physician information. A medical professional will administer all medications. In addition, please include any over-the-counter medication along with prescribed medications to be taken on an as needed basis. These medications will be held by camp staff and given to the child per their request.

1. \_\_\_\_\_ Dosage \_\_\_\_\_ Needed for \_\_\_\_\_  
*Name of Medication* *How many/time*

2. \_\_\_\_\_ Dosage \_\_\_\_\_ Needed for \_\_\_\_\_  
*Name of Medication* *How many/time*

3. \_\_\_\_\_ Dosage \_\_\_\_\_ Needed for \_\_\_\_\_  
*Name of Medication* *How many/time*

May we dispense Tylenol or Ibuprofen as needed?  Yes  No

**Medical Consent**

As the parent/guardian of \_\_\_\_\_ (name of child), I give Sacred Journey Hospice Foundation and Camp Horizon permission to administer medications as prescribed by this child’s physician. By signing this statement, I give release to the camp, its agents, employees, or representatives of any responsibilities for ill effects which may result from administering said prescribed medication.

I understand that in the case of emergency, every effort will be made to contact me. If I cannot be reached at the numbers supplied, I hereby give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and to order injection anesthesia or surgery for my child, as named herein.

I give permission for the use of photography, video and/or digital including my child in Foundation and camp publicity and promotion, for my child to participate in scheduled and supervised camp activities and for the release of medical records in case of injury or illness.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**RELEASE, WAIVER, INDEMNIFICATION, AND HEALTH AFFIRMATION**

By signing this Release, Waiver, Indemnification, and Health Affirmation below, I intend to be legally bound hereby, for myself, my minor children, my wards, my heirs, executors, administrators, successors and assigns, and in consideration of Camp Horizon's permitting me/my child/my ward to attend and participate in activities at Camp Horizon's contracted facility, I hereby release and forever discharge Camp Horizon and the Sacred Journey Hospice Foundation and any of its officers, directors, employees and agents from and against any and all damages of any kind whatsoever arising out of any injury, illness, infirmity, disease or loss of any kind, personal or property, to me/my child/my ward during or related to my/my child's/my ward's attendance at Camp Horizon. I understand and certify that my/my child's/my ward's participation in Sacred Journey Hospice Foundation and Camp Horizon and its activities is completely voluntary and I have familiarized myself with the program and activities in which I/my child/my ward will be participating. I recognize that certain hazards and dangers are inherent in Camp Horizon's activities and programs, and I acknowledge that Camp Horizon and Sacred Journey Hospice Foundation cannot ensure or guarantee that the participants, equipment, premises and/or activities will be free of hazards, accidents and/or injuries. I further recognize and have instructed my child or my ward, to the extent my child or ward will be attending and participating in activities of Camp Horizon, in the importance of knowing and abiding by the rules, regulations, and procedures for Sacred Journey Hospice Foundation's Camp Horizon. I also agree to defend, indemnify and hold Sacred Journey Hospice Foundation, Camp Horizon and its officers, directors, employees and agents harmless from and against any and all damages, costs, claims, demands, actions or causes of action sustained by any other person as a result of my/my child's/my ward's participation at Camp Horizon, whether caused in whole or in part by the negligence of Camp Horizon, Sacred Journey Hospice Foundation, its officers, directors, employees, or agents; provided, however, that this provision shall not operate to require indemnification for any gross negligence or willful misconduct of Camp Horizon. Further, I attest that my health insurance will cover any medical and hospital expenses that I/my child/my ward incur and that I have received approval from a doctor authorizing me/my child/my ward to participate in at least some of the activities at Camp Horizon. I further agree to inform Camp Horizon and Sacred Journey Hospice Foundation of any activities in which I/my child/my ward is not to participate.

**I have read and hereby accept the conditions described above. As the legal guardian of a minor applicant, I also give permission for myself and/or my minor child or ward to be treated by a doctor if needed.**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Minor Child or Ward \_\_\_\_\_