



MARY BRIDGE
CHILDREN'S HOSPITAL
PART OF THE ELUNA NETWORK



Bridges Center for
Grieving Children

CAMP ERIN® June 7, 8, and 9, 2024
CAMPER INFORMATION

CAMPER'S NAME: _____

Nickname (if any): _____ Camper's T-shirt size (please circle)

School: _____ Youth S YM YL
Adult S AM AL AXL AXXL

Home address: _____

City: _____ State/Zip: _____

Age: _____ Date of Birth: _____ Ethnicity: _____ Grade: _____ Gender: _____

Parent's/Guardian's Name: _____

Employer: _____

Daytime Phone: _____ Evening Phone: _____

E-mail: _____ Cell: _____

Siblings:	Name	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Church Affiliation/Preference: _____

Is your child a YMCA member? Yes No

Is either parent/guardian an active, reserve, or national guard military member or military veteran? Yes No
If so, what branch? _____

Was the deceased an active, reserve or national guard military member or military veteran? Yes No If so,
what branch? _____

Does the camper applicant qualify for or receive free lunch at school? Yes No

PERSON TO CONTACT IN THE EVENT OF AN EMERGENCY AT CAMP:

1. Name _____ Relationship To Child _____

Daytime Phone Number _____ Evening Phone _____

Alternate Phone Number _____ Cell Phone _____

2. Name _____ Relationship To Child _____
Daytime Phone Number _____ Evening Phone _____
Alternate Phone Number _____ Cell Phone _____

Has your child ever:

attended day camp? Yes No

had difficulty staying with a group? Yes No

Is your child a swimmer?

If yes, indicate level Beginner Intermediate Advanced

Please describe interests and hobbies your child has (ex. music, arts and crafts, sports, etc.): _____

How did you learn about this program?

Hospice School Physician Friend Newspaper

Other _____

Has your child attended **CAMP ERIN** before? Yes No

If so where _____ when _____

Parent/Guardian signature: _____ Date: _____

Relationship to camper: _____

LISA DUKE, MSW

CAMP ERIN Coordinator

Bridges Center For Grieving Children

PO Box 5299 MS: 11125-BRID

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253-403-1966

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CAMPER BEREAVEMENT HISTORY

CAMPER'S NAME _____

1. Name of person(s) who died _____

2. Relationship to child _____

3. Date of death _____ Age of deceased at time of death _____

4. Cause of death _____

5. Was the deceased a significant caregiver of the camper? Yes No

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

7. Did your child view the deceased after the death? Yes No

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

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

10. Has your child and/or family received counseling? Yes No

11. Has the child and/or family attended a support/group program? Yes No

12. Was the school notified that your child experienced a loss? Yes No

13. Please explain how your child indicates that he/she is grieving _____

14. Has your child experienced any other deaths? Yes No

If so, who _____ when _____

15. Have there been any other changes/stresses in your child's life (i.e. divorce, illness, relocation, etc.)?
Please explain

16. Has your child said or done anything recently that has concerned you? If so, what _____

18. Have any details of the death been withheld? _____

19. Has your child exhibited any of the following behaviors since the death?

PLEASE CIRCLE THE NUMBER WHICH BEST REFLECTS YOUR CHILD'S EXPERIENCE:

(1) STRONGLY DISAGREE TO (5) STRONGLY AGREE

Was this a problem
before the death?

Decrease in communication with parent/caregiver	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stealing	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Destruction of property	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Run away from home	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shown signs of self harm	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Caused harm to others	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unusual/inappropriate sexual behavior	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug/alcohol use	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bed wetting	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special fears	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Regression	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Behavior problems at home	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Behavior problems at school	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ongoing sleep disturbance/nightmares	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes in family relationships at home	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes in peer relationships at school	1	3	5	<input type="checkbox"/> Yes	<input type="checkbox"/> No

20. Have you and your child talked about him/her coming to **CAMP ERIN**? Yes No

21. What, if any, concerns do you have about your child coming to camp? _____

22. What, if any, concerns does your child express? _____

23. Other comments you wish to make: _____

Parent/Guardian signature: _____ Date: _____

Relationship to camper: _____

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CAMPER MEDICAL INFORMATION

CAMPER'S NAME: _____ Date of Birth: _____

Address: _____ Phone: _____

Does the camper have any of the following:

Physical Limitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Motion Sickness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Convulsions/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nosebleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Wears glasses/Contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dietary Restrictions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other (please specify) _____

Camper's Height: _____ Weight: _____

Who is your child's regular physician or clinic?

Physician's/Clinic's name: _____ Phone: _____

Is your child currently under the care of a counselor/mental health professional?

Yes No Name: _____ Phone: _____

Is your child allergic to any medication? Yes No

If yes, what medication: _____

Is your child allergic to anything else? Yes No

If yes list the allergy and reaction: _____

Does your child have an Epipen? Yes No

If so please bring it to camp: _____

Date of your child's latest Tetanus shot (Required)? _____

Any dietary restrictions (vegetarian, food allergies)? _____

Emergency contact name during camp _____

Phone: _____ Cell: _____

Emergency contact name during camp _____

Phone: _____ Cell: _____

Please complete medication information on back of form.

CAMPER MEDICATION INFORMATION

Does your child currently take medications? Yes No

Please list all of your child's current medications:

Name of Medication/Dosage: _____ For What? _____

Prescribed by: _____ Phone: _____

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Prescribed by: _____ Phone: _____

Name of Medication/Dosage: _____ For What? _____

Prescribed by: _____ Phone: _____

Name of Medication/Dosage: _____ For What? _____

Prescribed by: _____ Phone: _____

Will your child be taking medications at camp? If yes, please specify: _____

Parent/Guardian signature: _____ Date: _____

Relationship to camper: _____

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