



*A retreat for children with life-threatening illnesses and their families*

### **Family Application**

## **Bereavement Program November 10 – 14, 2010**

**Please complete and return this application to the Camp Sunshine office.**

**Parent/Guardian 1** \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Mobile phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Work Phone \_\_\_\_\_

**Parent/Guardian 2** \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Mobile phone \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Work Phone \_\_\_\_\_

We would like you to bring a support person with you to the session if a spouse is not available.

Name of adult support person: \_\_\_\_\_ Relationship to you \_\_\_\_\_

**Health Insurance Company** \_\_\_\_\_ **Policy Holder** \_\_\_\_\_  
 Telephone \_\_\_\_\_ **Policy No.** \_\_\_\_\_ **Group No.** \_\_\_\_\_

**Emergency Contact** (someone who will not be attending Camp with you)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

How did you find out about Camp Sunshine's Bereavement program? \_\_\_\_\_

**Deceased Child's Name** \_\_\_\_\_ **Date of birth** \_\_\_/\_\_\_/\_\_\_

Diagnosis \_\_\_\_\_  
**Date of diagnosis** \_\_\_/\_\_\_/\_\_\_ **Date child died** \_\_\_/\_\_\_/\_\_\_

**Name of Medical Center where child was treated** \_\_\_\_\_  
 Address \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Physician (Specialist)** \_\_\_\_\_ **Telephone** \_\_\_\_\_ **Fax** \_\_\_\_\_  
**Social Worker** \_\_\_\_\_ **Telephone** \_\_\_\_\_ **Fax** \_\_\_\_\_

Do you currently participate in a bereavement group?  Yes  No If so, how frequently? \_\_\_\_\_  
 Location \_\_\_\_\_ **Group Facilitator** \_\_\_\_\_ **Telephone** \_\_\_\_\_  
 May we contact the group facilitator?  Yes  No

Do your children currently participate in a bereavement group?  Yes  No If so, how frequently? \_\_\_\_\_  
 Location \_\_\_\_\_ **Group Facilitator** \_\_\_\_\_ **Telephone** \_\_\_\_\_

Have you or your children participated in a bereavement group in the past?  Yes  No  
 For how long did you attend? Yourself \_\_\_\_\_ Your children \_\_\_\_\_  
 When did you stop attending? Yourself \_\_\_\_\_ Your children \_\_\_\_\_  
 Why did you stop attending? Yourself \_\_\_\_\_ Your children \_\_\_\_\_

Have you participated in Camp Sunshine's Bereavement Program before?  Yes  No What year(s)? \_\_\_\_\_  
Have you attended a Bereavement Quilting Program before?  Yes  No If so, did you make something at the session?  Yes  No Please describe: \_\_\_\_\_

Are you interested in making a Quilt at this session?  Yes  No

Did your family attend Camp Sunshine when you child was under treatment?  Yes  No  
If you can recall, please indicate sessions or years: \_\_\_\_\_

Is there any particular activity you would like to see on the schedule during the Bereavement Program this year or in the future? \_\_\_\_\_

## FAMILY INFORMATION

**Please list all immediate family members who will be attending Camp, including yourself.  
(It is recommended that one additional support person accompany a parent.)**

**If any family member is under the care of a physician or mental health professional,  
please indicate the nature of the condition in the space provided.**

1. Parent's or Legal Guardian's\* Name \_\_\_\_\_  
Relationship to Deceased Child \_\_\_\_\_ Age at time of Camp Session \_\_\_\_\_  
Medical Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Emotional Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Please explain details of diagnosis and treatment \_\_\_\_\_

2. Parent's or Legal Guardian's\* Name \_\_\_\_\_  
Relationship to Deceased Child \_\_\_\_\_ Age at time of Camp Session \_\_\_\_\_  
Medical Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Emotional Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Please explain details of diagnosis and treatment \_\_\_\_\_

3. Child's Name \_\_\_\_\_  
Relationship to Deceased Child \_\_\_\_\_ Age at time of Camp Session \_\_\_\_\_  
Medical Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Emotional Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Please explain details of diagnosis and treatment \_\_\_\_\_

4. Child's Name \_\_\_\_\_  
Relationship to Deceased Child \_\_\_\_\_ Age at time of Camp Session \_\_\_\_\_  
Medical Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Emotional Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Please explain details of diagnosis and treatment \_\_\_\_\_

5. Child's Name \_\_\_\_\_  
Relationship to Deceased Child \_\_\_\_\_ Age at time of Camp Session \_\_\_\_\_  
Medical Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Emotional Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Please explain details of diagnosis and treatment \_\_\_\_\_

6. Child's Name \_\_\_\_\_  
Relationship to Deceased Child \_\_\_\_\_ Age at time of Camp Session \_\_\_\_\_  
Medical Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Emotional Problems  No  Yes  If yes, diagnosis \_\_\_\_\_  
Please explain details of diagnosis and treatment \_\_\_\_\_

**\*IF A LEGAL GUARDIAN WILL BE ACCOMPANYING A CHILD TO CAMP, ORIGINAL NOTARIZED DOCUMENTATION CONFIRMING THE GUARDIANSHIP MUST BE INCLUDED WITH THIS APPLICATION. WE WILL ALSO REQUIRE THIS DOCUMENTATION UPON YOUR ARRIVAL.**

**Permission to use photographs, video tape and/or audio tape of you and/or your family**

On behalf of myself and my family, I do hereby give Camp Sunshine, without consideration or compensation, permission to use photographs, videotape, and/or audiotape that may be taken or recorded while my child and family are attending Camp for promotional, educational, or fundraising activities. It is my understanding that these likenesses may be used to promote public and professional understanding and support of the program. I waive any right that I may have to inspect or approve the finished product or the use to which it may be applied.

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

**AUTHORIZATION FOR CAMP SUNSHINE TO PROVIDE MEDICAL TREATMENT**

I hereby give my consent for Camp Sunshine’s medical personnel to provide any and all reasonable and necessary medical treatment for my children. I understand and consent that I am responsible for all medical expenses incurred by Camp Sunshine on my behalf or on behalf of any members of my family.

**(Please include all of the children in your family who will be attending Camp Sunshine).**

Children’s Names	Date of Birth
1.	
2.	
3.	
4.	
5.	

This authorization shall remain in effect while we are attending Camp Sunshine at Sebago Lake in Casco, Maine.

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

I understand and agree that information disclosed regarding any of the individuals named in this application and related documents may be disclosed or otherwise released to appropriate organizations or individuals (including, but not limited to: members of the Camp Sunshine staff, insurance companies, and physicians) in connection with attendance at Camp Sunshine at Sebago Lake, Inc. I hereby confirm that the above information is true and accurate and that once accepted, I agree to update this information as you may request.

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

Parent/Guardian/Other Adult \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

Please return this application form to:

Camp Sunshine  
35 Acadia Rd.  
Casco, Maine 04015

If you have any questions, please call 207-655-3800.