2020 Bereavement Program Information

Eligibility Guidelines

- Camp Sunshine offers bereavement programs for families who have had a child die as the result of one of the illnesses it serves.
- Priority will be given to families who previously attended Camp Sunshine with their child.
- If both parents are unable to attend, we encourage families to include a second adult as a support person.
- Immunization records are required for all applicants under 26 years of age.
- Completed applications will be reviewed on a first-come, first-served basis, and should be received at least one month prior to the session start date. (If seeking to apply within one month of the program, please call Camp Sunshine to inquire about availability.)
- Families may attend one session per program year.

Things to Know About Camp

- Meals, lodging, and activities are all provided at no cost to families thanks to the generosity of our donors.
- A pediatric physician is present on-site during all Camp Sunshine sessions.
- Family suites can comfortably sleep 6 and include a private bathroom, heat/AC, a mini-fridge, and microwave oven.
- Transportation assistance may be available for families who would otherwise be unable to attend Camp. Funding is prioritized for families attending for the first time. Please check the box on the first page of the application to request assistance. If funding is requested, you will receive further information at the time of acceptance.

Applications may be mailed or faxed to:
Camp Sunshine
35 Acadia Road
Casco, ME 04015
Phone: (207) 655-3800
Fax: (207) 655-3825
www.campsunshine.org
2020 Bereavement Application Checklist

Please use the following checklist to ensure that your family’s application is complete.

☐ Family Forms
  - Enclosed four-page application to be completed by the parent/guardian

☐ Immunization Records
  - A complete and up-to-date immunization record must be included for each person under 26 years of age who is applying to attend Camp.
  - For the optimal health and safety of all campers, staff, and volunteers, Camp Sunshine requires that all campers who can receive immunizations meet the age-appropriate immunization schedule as set forth by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
  - At a minimum, campers aged 5 years and older should meet the same immunization requirements as those for school-aged children set forth in the State of Maine School Immunization Law (20-A MRSA §§6352-6358):
    - 5 DTaP (4 DTaP if the 4th is given on or after the 4th birthday)
    - 4 Polio (if the 4th dose is given before the 4th birthday, an additional age-appropriate inactivated polio immunization should be given on or after the 4th birthday)
    - 2 MMR (measles, mumps, rubella)
    - 1 Varicella (chickenpox) or reliable history of disease
  - Camp Sunshine also requires that children aged 11 and older receive the meningococcal vaccine and TDaP booster prior to attendance.

☐ Health History Forms
  - A separate Health History form is required for each person (including adults) planning to attend Camp. The Health History forms do not require a physician signature.

☐ Next Steps
  - You will be contacted once your application has been processed. Acceptances and other updates will be provided as soon as possible.
A retreat for children with life-threatening illnesses and their families

2020 Bereavement Program
November 5 – 9
Family Application
Please print clearly using black or blue ink.

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

Parent/Legal Guardian 1 _______________
Relationship __________________________
Date of Birth __________________________
Address __________________________________________
City, State, Zip __________________________
Home Phone __________________________
E-mail _______________________________________
Mobile phone __________________________
Employer ___________________________________
Work Phone __________________________

Have you been in the Armed Forces? ☐ Yes ☐ No

Have you been in the Reserves? ☐ Yes ☐ No

Marital status (please indicate marital status of parents and explain any particular familial circumstances and/or custodial arrangements of which we should be aware):

________________________________________________________________________________________

________________________________________________________________________________________

We would like you to bring a support person with you to the session if a partner is not available to attend.
Name of adult support person: ___________________________ Relationship to you ___________________________

Health Insurance Company __________________________ Policy Holder __________________________ Group No. _______
Telephone __________________________ Policy No. __________________________

Emergency Contact (someone who will not be attending Camp with you)
Name __________________________ Relationship __________________________ Telephone __________________________

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 __________________________ Email __________________________
Social Worker __________________________ Telephone __________________________ Email __________________________

How did you find out about Camp Sunshine’s Bereavement Program? __________________________

FOR OFFICE USE ONLY

☐ Family Forms
☐ Immunizations
☐ Health History Forms
Additional Questions

Do you currently participate in a bereavement group? [ ] Yes [ ] No
If so, how frequently? __________________________
Location _________________________________________
Group Facilitator’s Name __________________________
Telephone ____________________ Email ___________________________

Do your children currently participate in a bereavement group? [ ] Yes [ ] No
If so, how frequently? ________________
Location _________________________________________
Group Facilitator’s Name __________________________
Telephone ____________________ Email ___________________________

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 __________________

May we contact any of the professionals listed on the application? [ ] Yes [ ] No

Have you participated in Camp Sunshine’s Bereavement Program before? [ ] Yes [ ] No
What year(s) _________________________________________

Did your family attend Camp Sunshine when your child was on 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? _________________________________________

Is there an activity in any other bereavement program you have found helpful? [ ] Yes [ ] No
If so, please describe _________________________________________

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

*For those new to Camp, the quilting program is designed so that families are matched up with a volunteer quilter. Additional information will be sent prior to session. If you have any questions please do not hesitate to call us.*
WHO WILL BE ATTENDING CAMP?

Please list all immediate family members who will be attending Camp, including yourself.  
(It is recommended that one additional support person accompany a single parent/guardian or a parent/guardian whose partner cannot attend.)

<table>
<thead>
<tr>
<th>Parents'/Legal Guardians'/ Support Person’s Names</th>
<th>Relationship to child</th>
<th>Medical or Emotional diagnosis/ concern?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. _______________________________</td>
<td>_____________________</td>
<td>☐ No ☑ Yes ______________________________</td>
</tr>
<tr>
<td>2. _______________________________</td>
<td>_____________________</td>
<td>☐ No ☑ Yes ______________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Siblings’ Names</th>
<th>Relationship/ Age at time of Camp</th>
<th>Medical or Emotional diagnosis/ concern?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. _______________________________</td>
<td>________/____yr</td>
<td>☐ No ☑ Yes ______________________________</td>
</tr>
<tr>
<td>2. _______________________________</td>
<td>________/____yr</td>
<td>☐ No ☑ Yes ______________________________</td>
</tr>
<tr>
<td>3. _______________________________</td>
<td>________/____yr</td>
<td>☐ No ☑ Yes ______________________________</td>
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<tr>
<td>4. _______________________________</td>
<td>________/____yr</td>
<td>☐ No ☑ Yes ______________________________</td>
</tr>
<tr>
<td>5. _______________________________</td>
<td>________/____yr</td>
<td>☐ No ☑ Yes ______________________________</td>
</tr>
<tr>
<td>6. _______________________________</td>
<td>________/____yr</td>
<td>☐ No ☑ Yes ______________________________</td>
</tr>
</tbody>
</table>

*PLEASE NOTE: ALL CHILDREN UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT AND/OR LEGAL GUARDIAN WHEN ATTENDING CAMP. IF A LEGAL GUARDIAN WILL BE ACCOMPANYING A CHILD TO CAMP, ORIGINAL NOTARIZED COURT DOCUMENTATION CONFIRMING THE GUARDIANSHIP MUST BE INCLUDED WITH THIS APPLICATION. IF MARITAL STATUS IS SEPARATED OR DIVORCED, PARENTS/LEGAL GUARDIANS MAY BE REQUIRED TO PROVIDE ADDITIONAL INFORMATION.*
Permission to use photographs, videotape and/or audiotape of you and/or your family for promotional, educational and/or fundraising activities.

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)

Permission to use photographs and/or videotape of you and/or your family for postings on Social Media.

On behalf of myself and my family, I do hereby give Camp Sunshine, without consideration or compensation, permission to use photographs and/or videotape that may be taken or recorded while my child and family are attending Camp for postings on social media including but not limited to postings on Camp Sunshine at Sebago Lake's official Facebook page. 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).

<table>
<thead>
<tr>
<th>Children’s Names</th>
<th>Date of Birth</th>
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<tbody>
<tr>
<td>1.</td>
<td></td>
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<td>7.</td>
<td></td>
</tr>
</tbody>
</table>

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
Fax: 207-655-3825

If you have any questions, please call 207-655-3800.
A retreat for children with life-threatening illnesses and their families

Health History Form

Please complete pages 1 and 2 of this form for each person attending. Information must be filled out by a parent/guardian for all minors. Any changes to this form should be provided to Camp Sunshine staff prior to arrival.

Name__________________________     Birth date_________     Age______     Gender__________________

Parent/guardian (if applicable) ____________________________

Name (in full) as you would like it to appear on the nametag _______________________________________

Address___________________________     City_______________________     State____     Zip________

Insurance Information

Is the participant covered by family medical/hospital insurance? □ yes □ no
Carrier or plan name ____________________________     Policy No. ____________     Group No. ____________

Medications

Please list all medications taken routinely. Bring enough medication to last the entire camp session. Keep all medication in original packaging/bottle that identifies the prescribing drugs.

Med #1______________________     Dosage_____________     Specific times taken each day____________
Reason for taking__________________________________________

Med #2______________________     Dosage_____________     Specific times taken each day____________
Reason for taking__________________________________________

Med #3______________________     Dosage_____________     Specific times taken each day____________
Reason for taking__________________________________________

General Questions (Explain “yes” answers)

1. Have you had any recent injury, illness, or infectious disease? □ yes □ no
2. Do you have a chronic recurring illness/condition? □ yes □ no
3. Have you ever been hospitalized? □ yes □ no
4. Have you ever had surgery? □ yes □ no
5. Have you ever had a head injury? □ yes □ no
6. Have you ever been knocked unconscious? □ yes □ no
7. Have you ever passed out during exercise? □ yes □ no
8. Have you ever been dizzy during exercise? □ yes □ no
9. Have you ever had a seizure? □ yes □ no
10. Have you ever had chest pain during or after exercise? □ yes □ no
11. Have you ever had high blood pressure? □ yes □ no
12. Have you ever been diagnosed with a heart murmur? □ yes □ no
13. Do you have diabetes? □ yes □ no
14. Do you have asthma? □ yes □ no
15. Have you ever had an eating disorder? □ yes □ no
16. Have you ever had emotional difficulties for which professional help was sought? □ yes □ no

Please explain “Yes” answers, noting the number of the questions_______________________________________

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
Name _________________________

Allergies

Describe reaction and management of the reaction

Medication allergies (list)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Food allergies (list)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Other allergies (list)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Dietary Restrictions

☐ Does not eat pork ☐ Does not eat eggs ☐ Does not eat dairy

☐ Other (describe) ____________________________________________________

Explain any restriction to activities (e.g. what cannot be done, what adaptation or limitations are necessary)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Use this space to provide any additional information about participant’s behavior and physical, emotional, or mental health about which camp should be aware

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

To the best of your knowledge, which of the following has the participant had?

☐ Chickenpox ☐ Measles ☐ German Measles ☐ Mumps ☐ Hepatitis A ☐ Hepatitis B

☐ Hepatitis C ☐ TB Mantoux Test Result: ☐ Positive ☐ Negative

Name of family physician ___________________________ Phone________________

*(YOU DO NOT NEED A PHYSICIAN’S SIGNATURE)*

Parent/Guardian/Adult Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities as noted.

Signature of custodial parent/guardian or adult camper ___________________________ Date ____________

Printed Name ___________________________ Date ____________

If this health history form is for yourself as an adult family member or support person, please complete the section below:

I hereby give permission to Camp Sunshine’s medical personnel to provide emergency treatment and basic first aid for the person herein described. I further understand and consent that I am responsible for all medical expenses.

Signature of adult camper ___________________________ Date ____________

Printed Name ___________________________ Date ____________