



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

## **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](http://www.campsunshine.org)



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## **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 MRS §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.



Travel Assistance Requested

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## 2020 Bereavement Program

May 21 - 26

### 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): \_\_\_\_\_

Parent/Legal Guardian 2 \_\_\_\_\_

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

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 \_\_\_\_\_

Telephone \_\_\_\_\_ Policy No. \_\_\_\_\_ Group 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.)

Parents'/Legal Guardians'/ Support Person's Names	Relationship to child	Medical or Emotional diagnosis/ concern? If "Yes," please explain and include on Health History Form
1. _____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
2. _____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Siblings' Names	Relationship/ Age at time of Camp	Medical or Emotional diagnosis/ concern? If "Yes," please explain and include on Health History Form
1. _____	_____ / ____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
2. _____	_____ / ____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
3. _____	_____ / ____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
4. _____	_____ / ____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
5. _____	_____ / ____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
6. _____	_____ / ____ yr	<input type="checkbox"/> No <input type="checkbox"/> Yes _____

**\*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).**

Children's Names	Date of Birth
1.	
2.	
3.	
4.	
5.	
6.	
7.	

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.



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### 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 \_\_\_\_\_  
 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 \_\_\_\_\_  
 Printed Name \_\_\_\_\_ Date \_\_\_\_\_