APPLICATION FOR 2019

Check the camp location for which you are applying:

❑ **Camp Dragonfly at Swatara (May 31, June 1 & 2)**
OR
❑ **Camp Dragonfly at Hebron (June 7, 8 & 9)**

How did you learn about Camp Dragonfly?
❑ Newspaper ❑Church Bulletin ❑Hospice Brochure ❑Radio/TV ❑Counselor ❑Hospice Staff Member
❑ Hospice of Central PA Website ❑ Social Media
❑ Other (please specify): _____

Directions:

Please complete the following application by answering all questions as completely as possible. The more information you can provide, the better we can determine how to make your camper's weekend the best possible experience for him/her.

The child's parent or legal guardian must complete this application and provide all signatures.

If you need assistance in completing this application, please call Hospice of Central PA.

Please return the completed application as soon as possible as campers are accepted on a first come, first served basis. **All application materials must be received prior to camper interviews being scheduled. Please include a picture of your child with the completed application.**

Hospice of Central PA
1320 Linglestown Rd
Harrisburg, PA 17110
Email to lhinkle@hospiceofcentralpa.org

Main office: 717-732-1000 Pottsville Area: 570-628-2290 Toll free: 1-866-779-7374

Child's Name: _____

Declaration:
The information on this application is accurate and correct to the best of my knowledge. I understand that if changes occur regarding the information supplied on this application, it is the responsibility of the individual completing this application to contact Hospice of Central PA regarding the change(s).

_____ _____
Signature of Individual Completing Application Date

Print Name: _____

Relationship to child: _____

BEREAVEMENT HISTORY

(To be completed by the parent or legal guardian)

Camper's Name_____
First Middle Last

Camper's Nickname (if any) _____

Home Address _____

City_____ County _____ State_____ Zip Code_____

Birth date _____ Age _____ Grade (this fall) _____ Gender: ❑Male ❑Female

Ethnicity:

- ❑ Hispanic or Latino
- ❑ Non-Hispanic or Non-Latino

Race:

- ❑ White
- ❑ Black or African American
- ❑ Asian
- ❑ American Indian or Alaska Native
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Another Race: _____
- ❑ Two or More Races

Parent/Guardian's Name _____

Parent/ Guardian Email _____

If Guardian, how are you related to the child? _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____

Please include as many details as possible when answering the following questions. Attach extra pages if necessary.

1. Name of person who died _____

2. How was your child related to the deceased? _____

3. Describe the relationship that existed between your child and the deceased. _____

_____

4. Date of the death_____ 5. Cause of death _____

6. Child's age at the time of the death _____ 7. Age of the deceased at time of death _____

8. Was your child present at the time of death? ❑Yes ❑No
   If yes, how did the child deal with the death and how was he or she supported?

   If no, how did your child learn of the death and how did the family, including your child, respond at that time?

9. What is your child's understanding of the death?

10. Did your child attend the funeral or memorial service? ❑Yes ❑No
    If yes, describe their reaction.

11. What changes (if any) did you notice in your child's behavior or personality at the time of the death and during the weeks and months following the death?

12. Please describe how you feel your child is grieving at this time.

CAMPER'S NAME:_____

13. Does your child currently exhibit any of the following behaviors?

❑ Afraid to go to sleep	❑ Anger toward parent/guardian
❑ Nightmares	❑ Clinging to parent/guardian
❑ Bed-wetting	❑ Difficulty with schoolwork
❑ Fighting	❑ Cruelty to animals
❑ Destructive behavior	❑ Using drugs/alcohol
❑ Feels isolated at home/school	❑ Refuses to talk about death

❑ Other: _____

Please explain all items checked above: _____
_____
_____

14. Has your child ever received support from a professional counselor (for example, a psychologist, psychiatrist, pastoral counselor, or school counselor)? ❑Yes ❑No

If yes, **provide the name, address and phone number for each counselor**.
_____
_____
_____

May we contact the counselor(s)? ❑Yes ❑No

15. Has your child experienced the death of more than one person they loved? ❑Yes ❑No
Has your child had to change schools? ❑Yes ❑No
If yes to either question, please explain, with dates if possible.

16. Have there been any other changes or stressful situations in your child's life such as divorce, illness, a move, other losses, etc. within the year before or since the death? Please describe.

17. Does your child have any problems getting along with friends/peers, family members or authority figures such as teacher, counselors, coaches, etc.?
❑Yes ❑No **If yes**, please explain.

18. What are your child's expectations for Camp Dragonfly?

19. What are your expectations for Camp Dragonfly?

20. Please tell us something about your child which makes you especially proud:

_____

21. Please provide any additional information you feel necessary:

_____

Signature of Parent/Guardian **Date**

Printed Name of Parent/Guardian

"GETTING TO KNOW YOU"
(To be filled out by the prospective camper, if possible)

Camper's Name_____

Camper will be given TWO Camp Dragonfly t-shirts at camp.
The camper's T-shirt size: Child: ❑S ❑M ❑L

Adult ❑S ❑M ❑L ❑XL

So that we can try to make sure the weekend includes activities that you enjoy, please answer the following questions.

Please check all activities in which you enjoy.

❑ swimming	❑ volleyball	❑ boating
❑ nature walks/hiking	❑ arts/crafts	❑ creative writing
❑ basketball/sports	❑ music	❑ fishing

Do you know how to swim? ❑Yes ❑No

What other activities do you enjoy?

Have you ever spent the night away from home? ❑Yes ❑No

Have you ever been camping? ❑Yes ❑No

Are there any foods you can't eat? ❑Yes ❑No
If Yes, which foods:

What else would you like us to know about you?

CAMPER HEALTH HISTORY FORM

(To be completed by parent or guardian)

Please Print:

Camper's Name: _____
First Middle Last

Birth date _____ Age _____ Gender: ❑Male ❑Female

Child's Current Height _____ Child's Current Weight _____

Address _____

City _____ State _____ Zip Code _____

Mother's/Guardian's Name: _____

Relationship to Child/Camper: _____ Cell Phone ( ) _____

Daytime Phone ( ) _____ Evening Phone ( ) _____

Address: _____

Email Address: _____

Father's/Guardian's Name: _____

Relationship to Child/Camper: _____ Cell Phone ( ) _____

Daytime Phone ( ) _____ Evening Phone ( ) _____

Address: _____

Email Address: _____

Immunizations History:

(Please complete information below **or** provide a copy of your child's most current immunization record. If you need help with the following information, contacting your child's doctor's office will be helpful in obtaining this information)

Immunizations	Year Primary Series Completed	Year of Last Booster
DPT		
Measles		
Mumps		
Oral Polio		
Rubella		
Tetanus Shot		

Tuberculin Test: Type_____ Year last given _____ Result _____

Allergies

❑ **No known allergies**

Does your child have allergic reactions to:

Medicines? ❑Yes ❑ No

Name of medicine	What happens? (rash, eye watering, swelling, breathing problems, etc)

Food? ❑Yes ❑No

Food	What happens?

CAMPER'S NAME:_____

Insect bites? ❑Yes ❑ No

Insect	What happens?	How do you treat?

Medical supplies such as tape, band-aids, latex? ❑Yes ❑ No

Medical Supply	What happens?	How do you treat?

Other allergies? ❑Yes ❑ No **If yes, please specify**

Cause of allergy	What happens?	How do you treat?

Health History:

Check all that apply:

❑Asthma
❑Attention Deficit Disorder
❑Constipation
❑Convulsions/seizures
❑Diabetes
❑Diarrhea
❑Ear Infections
❑Emotional Problems
❑Epilepsy
❑Fainting
❑Hearing Impairment
❑Heart Disease
❑Hemophilia
❑Incontinence (toileting problems)
❑Kidney Disease
❑Low Blood Sugar
❑Menstrual Problems
❑Migraines
❑Motion Sickness
❑Nightmares
❑Nosebleeds
❑Sickle Cell Anemia
❑Sleep Walking
❑Special Dietary Need
❑Wears Contacts
❑Wears Glasses

With regard to those conditions you have checked above, please **add any information** that the camp staff or the adult in charge of your child should know. Also, list any activities in which your child should **not** participate.

_____

_____

CAMPER'S NAME:_____

Date of child's last physical examination _____
Were any medical or emotional problems noted at that time? ❑ Yes ❑ No **If Yes**, Explain.

_____

Is your child currently under a physician's care for a medical or emotional problem? ❑ Yes ❑ No

If Yes, explain:

_____

_____

Has your child recently had a serious illness or injury requiring medical attention? ❑ Yes ❑ No

1) An illness lasting longer than a week? (Explain)

_____

2) An operation or fracture? (Explain)

_____

Is your child on a physician-prescribed medication that is taken on a regular basis? ❑ Yes ❑ No
If Yes, Explain.

_____

_____

Is your child restricted from participating in any physical activity? ❑ Yes ❑ No
If yes, specify activity.

_____

_____

Is there any other health reason(s), other than the information provided by you on this form, why your child **<u>should not</u>** participate in any of the Camp Dragonfly activities? **If so, please explain**.

_____

_____

Please provide any additional health or medical information you feel necessary:

_____

_____

CAMPER'S NAME:_____

Please note: It is very important that your child take all medications prescribed by his/her physician during Camp Dragonfly. Camp is NOT the time to give your child a break from taking his/her medications.

If your child takes medications for school attendance they need to take them at Camp so they can participate in activities and have a positive Camp experience.

If your child arrives at Camp without their medications you will be asked to go home and return with the medications before your child will be signed into camp.

Dietary Information:

Does your child have any problems with eating? ❑Yes ❑No

If Yes, please explain.

_____

_____

Please list any dietary needs:

_____

Is your child a vegetarian? ❑Yes ❑No

Please provide any additional health information you feel necessary/important for us to be aware of:

_____

_____

_____

_____

Emergency Contact Information:

In case of emergency DURING CAMP and parent/guardian cannot be reached, contact:

1. Print Name _____ Relationship to Camper _____

   Daytime Phone ( ) _____ Evening Phone ( ) _____

2. Print Name _____ Relationship to Camper _____

   Daytime Phone ( ) _____ Evening Phone ( ) _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Should a medical emergency arise during my child's participation in a Camp Dragonfly activity, I consent to:

1) the administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or medical facility identified below, the Camp Dragonfly physician, the Camp Dragonfly nurse or the Camp Dragonfly director, and
2) the immediate administration of life-sustaining measures deemed necessary under the circumstances.

_____

Signature of Parent/Guardian **Date**

Medical Insurance Information:

Company _____

Policy Number _____ Policyholder's Name _____

Preferred Physician/Medical Facility _____

Physician's Phone Number : Daytime ( ) _____ Evening ( ) _____

CAMPER'S NAME: _____

PHYSICIAN'S MEDICATION ORDER FORM

****FOR ADDITIONAL MEDICATIONS NOT INCLUDED IN ORIGINAL APPLICATION****

If your child is taking prescription medication, please send this form to your doctor to complete. Have your doctor return the form to you so that you can sign the authorization at the bottom of the page, and then return to us.

If your child is NOT taking any prescription medications, please check here □ and initial _____.

Please note: The first dose of a new medication must be administered at home.

CAMPER'S NAME: _____
First Middle Last

PLEASE PRINT:
The following medications must be given during camp:

MEDICATION	DOSAGE	ROUTE	TIME(S) TO BE GIVEN
1.			
2.			
3.			

Administration considerations (to be taken with water, food, milk, etc.?) _____

_____

List any reasons for not giving medication at the prescribed time (for example- vomiting, fever, drowsiness, convulsions):

_____

_____

MUST BE SIGNED BY PHYSICIAN

Physician's Signature_____Date_____

Print name

PARENT/GUARDIAN AUTHORIZATION

I/We authorize and request Camp Dragonfly personnel to administer the medication(s) prescribed by our physician, and in so doing, release Camp Dragonfly, its agents, employees or representatives of any liability for any adverse or ill effects which may result from the administration of said prescribed medication.

Signature of Parent/Guardian_____Date_____

Print Name_____

OVER THE COUNTER MEDICATION PERMISSION FORM (Signed by Parent/Guardian)

Please Print:
Child's Name _____
First Middle Last

Medication dosage will be given according to age/weight guidelines.

The Camp Dragonfly nurse has permission to administer to the child listed above the following over the counter medications:

(Please Check)

☐ **all of the listed medications are acceptable**

	Generic medicine (form)	Purpose	Brand example
❑	Ibuprofen (pills)	Pain relief	Advil, Motrin
❑	Acetaminophen (pills or chewable)	Pain relief; fever	Tylenol
☐	Diphenhydramine Hydrochloride (pills or liquid)	Itching/hay fever	Benadryl
☐	Diphenhydramine Hydrochloride (cream)	Skin irritation	Benadryl
☐	Calamine and zinc oxide (lotion)	Skin protectant/ poison ivy	Calamine lotion
❑	Bismuth subsalicylate/aspirin-like (liquid)	Upset stomach	Pepto bismol
❑	Calcium carbonate chewable (pills)	Upset stomach	Tums
❑	Loperamide hydrochloride (pills)	Diarrhea	Imodium
☐	PolymyxinB, bacitracin, neomycin (ointment)	Prevention of infection cuts or abrasion	Triple antibiotic
☐	Povidone-Iodine (ointment)	Prevention of infection for cuts or abrasion	Betadine
❑	Deet (spray)	Insect repellent	Cutter; OFF
❑	Benzocaine (spray)	Antiseptic, pain, itch	Solarcaine
❑	Dextromethorphan, phenylephrine, chlorpheniramine (liquid)	Cough, decongestant, runny nose	Robitussin

Signature of Parent/Guardian_____ **Date**_____

Print Name_____

CAMPER RELEASE OF LIABILITY

(This signed release is required for camp attendance)

I hereby release and discharge Hospice of Central PA its agents, employees, volunteers, directors and officers from any claims, legal responsibility and/or liability for any personal injuries or illnesses, either physical or emotional, or injury to property, real or personal, whether that injury is due to negligence or any other reason which may occur while my child attends Camp Dragonfly.

Name of Child_____
First Middle Last

Name of Parent/Guardian *(Please print*) _____

If Guardian, state relationship to child _____

_____

Signature of Parent/Guardian **Date**

PUBLICITY RELEASE

A volunteer photographer will be present during the Camp Dragonfly weekend to help record weekend activities for a camp photo album and future publicity. It is also possible that camp activities will be videotaped for future camp volunteer training, as well as for community-wide education. In addition, with Hospice of Central PA staff permission and supervision, the news media may wish to photograph videotape and/or interview the volunteers and children attending camp.

I hereby consent to having my child named above photographed, videotaped and/or interviewed, and authorize the publishing of such materials in any news or social media.

_____

Signature of Parent/Guardian **Date**

Packing List for Camper

Basic Gear **PLEASE PUT INITIALS ON ALL BELONGINGS**

sleeping bag (or sheets and a blanket)
pillow and pillow case
flashlight with good batteries
water bottle

Clothing

pair of sneakers
extra pair of sneakers or sturdy/comfortable walking shoes
jacket or sweater
sweatshirt
2 shirts--at least one long-sleeved
2 pairs pants/jeans (or shorts if weather is warm)
3-4 pairs of socks
3-4 changes of underwear
1 pair of pajamas or sweat suit
1 swimsuit and towel- **note: two piece bathing suits/bikinis are not permitted**
rain gear

Note: each camper will be provided with two Camp Dragonfly t-shirts at camp

Toiletries

toothbrush and toothpaste
deodorant
soap in plastic container or bag
bath towel
washcloth
comb and/or brush

Optional Items

sunscreen
insect repellent
hiking shoes
fishing gear (if your child will be fishing while at camp)
photo of deceased loved one for memory table

REMEMBER.....

If siblings are attending camp together, please make certain each child has his or her own toiletry items since they may be assigned to different cabins.

Since Camp Dragonfly cannot be responsible for lost or missing items, we require that valuables **such as radios, video games or jewelry be left at home**. Also, since all meals, snacks and activities are being provided free of charge, **there is no need for your child or children to have money with them. Please leave all cell phones at home.** Cell phones and/or other inappropriate camp items will be given to parent/guardian at camp check-in to take home

In addition, please leave items like perfume, hairspray, mousse, gum and candy at home, since these items tend to attract insects like ants, bees and wasps.