APPLICATION FOR 2024

CAMP HEBRON, HALIFAX, PA—JUNE 7 – 9, 2024

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 Pennsylvania.

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 YOUR COMPLETED APPLICATION.

Hospice of Central Pennsylvania
1320 Linglestown Rd
Harrisburg, PA 17110

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 Pennsylvania 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) _____ Sex: ❑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? What was explained to your child about 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 (i.e. behaviors and interactions with others).

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
If yes, please have the counselor sign the attached disclosure form.

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 for us to better know your child:

_____

_____

_____

_____

_____

_____

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_____

Preferred Name (to be used for name tag) _____

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 ❑XXL

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'S NAME: _____ Nickname: _____

CAMPER HEALTH HISTORY FORM

(To be completed by parent or guardian)

Please Print:

Camper's Name: _____
First Middle Last

Birth date _____ Age _____ Sex: ❑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		
COVID - 19		

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?

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 Hyperactivity Disorder
❑Constipation
❑Convulsions/seizures
❑COVID-19
❑Diabetes
❑Diarrhea
❑Ear Infections
❑Emotional Problems
❑Epilepsy
❑Fainting
❑Hearing Impairment
❑Heart Disease
❑Hemophilia
❑Incontinence (toileting problems)
❑Kidney Disease
❑Low Blood Sugar
❑Menstrual Problems
❑Mental Health History (anxiety, depression, etc.)
❑Migraines/headaches
❑Motion Sickness
❑Nightmares
❑Nosebleeds
❑Sickle Cell Anemia
❑Sleep Walking
❑Special Dietary Need
❑Stomach aches
❑Wears Contacts
❑Wears Glasses
❑Wears Hearing Aids

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.

_____

_____

_____

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:

_____

_____

_____

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 ( ) _____

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.				
4.				
5.				

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 ointment
❑	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 Name: _____

ACKNOWLEDGMENT OF RISK, WAIVER AND RELEASE OF LIABILITY

WARNING: There are significant elements of risk in any adventure, sport, or activity that may occur in Camp Dragonfly (referred to herein as "activity" or "activities"). The same elements that contribute to the unique character of the activity can be causes of loss or damage or accidental injury, illness, or in extreme cases permanent trauma or death. By signing this Acknowledgment of Risk, Waiver and Release of Liability, you are agreeing to release the individuals and/or entities identified below from any and all liability from any such occurrence arising from the activity.

ACKNOWLEDGMENT AND ASSUMPTION OF RISKS: I certify that (a) I am at least eighteen (18) years of Age and legally able to sign this document for my child. I acknowledge that my child is physically and mentally capable of safely participating in the activities. I recognize that there are inherent risks and dangers in participating in the activities. These risks may result in serious injury or death. I understand that certain foreseeable and unforeseeable events can contribute to the unpredictability of the activity and that personal property may be lost or damaged. In recognition of the inherent risks of the activity which I, or the minor on whose behalf I am signing this document, will engage in, I assume full risk and responsibility for personal injury, accidents or illness (including death), and any related expenses, including attorneys' fees and insurance deductibles. I also assume risk and responsibility for damage to or loss of personal property. I also assume risk and responsibility for accidents or injuries that may be caused by the negligence of principles, officers, directors, shareholders, employees, agents and/or volunteers of Camp Dragonfly and Hospice of Central Pennsylvania, whether such negligence is comparable or contributory.

WAIVER AND RELEASE OF LIABILITY: IN CONSIDERATION OF THE USE AND OPERATION OF THE ACTIVITIES PROVIDED BY CAMP DRAGONFLY, AND IN RECOGNITION OF THE INHERENT RISKS OF SAID ACTIVITIES, I AGREE, ON BEHALF OF MYSELF, MY HEIRS, REPRESENTATIVES, SUCCESSORS, EXECUTORS, ADMINISTRATORS, AND ASSIGNS, TO HEREBY RELEASE WAIVE, DISCHARGE, AND AGREE NOT TO SUE CAMP DRAGONFLY AND HOSPICE OF CENTRAL PENNSYLVANIA, ITS PRINCIPALS, OFFICERS, DIRECTORS, SHAREHOLDERS, AGENTS, EMPLOYEES, AND/OR VOLUNTEERS, FOR ANY AND ALL CAUSES OF ACTION OF ANY NATURE WHATSOEVER WHICH I MAY HAVE, ON ACCOUNT OF ANY PERSONAL INJURY, PROPERTY DAMAGE, DEATH, OR ACCIDENT OF ANY KIND, ARISING OUT OF OR IN ANY WAY CONNECTED WITH THE USE OF THE AFORESAID ACTIVITIES, AND/OR ANY OF THE FACILITIES AND/OR EQUIPMENT AND I AGREE TO INDEMNIFY AND HOLD HARMLESS THE PERSONS OR ENTITIES MENTIONED IN THIS PARAGRAPH FROM ANY AND ALL LIABILITIES OR CLAIMS MADE BY OTHER INDIVIDUALS OR ENTITIES AS A RESULT OF MY ACTIONS. I FURTHER AGREE TO WAIVE AND RELEASE ANY CLAIMS AGAINST AND NOT TO SUE CAMP DRAGONFLY AND HOSPICE OF CENTRAL PENNSYLVANIA, ITS PRINCIPALS, OFFICERS, DIRECTORS, SHAREHOLDERS, AGENTS, EMPLOYEES, AND/OR VOLUNTEERS, FOR ANY INJURY OR DAMAGE CAUSED BY ACTS OF ITS/THEIR OWN NEGLIGENCE WHICH MAY CAUSE PHYSICAL/MENTAL INJURY OR PHYSICAL DAMAGE TO MY PROPERTY.

WARNING, WAIVER, AND RELEASE OF LIABILITY RELATING TO CORONAVIRUS/ COVID-19: The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID 19 is believed to be extremely contagious and the state of medical knowledge of its transmission, infection and treatment continues to evolve. The COVID-19 virus is believed to be spread from

person-to-person contact and/or by contact with contaminated surfaces, objects, and even possibly through particles in the air. Infected individuals may be completely asymptomatic and still potentially spread the virus. Evidence has demonstrated that COVID-19 can cause serious and potentially life threatening illnesses, including death. Hospice of Central Pa cannot prevent you, or any minors on whose behalf you may be signing this release, from being exposed to, contracting, or spreading COVID19 while utilizing Camp Dragonfly's facilities, services, equipment, or premises. It is not possible to completely prevent the presence of the COVID-19 virus. THEREFORE, IF YOU CHOOSE TO USE CAMP DRAGONFLY'S SERVICES AND/OR ENTER ONTO CAMP DRAGONFLY'S PREMISES, YOU MAY BE EXPOSING YOURSELF TO AND/OR INCREASING YOUR RISK OF CONTRACTING OR SPREADING COVID-19. I HAVE READ AND UNDERSTOOD THE ABOVE WARNING REGARDING COVID-19, I HEREBY CHOOSE TO ASSUME THE FULL RISK ANDRESPONSIBILITY OF CONTRACTING COVID-19 FOR MYSELF AND/OR ANY MINORS ONWHOSE BEHALF I AM SIGNING THIS RELEASE, IN ORDER TO PARTICIPATE IN CAMP DRAGONFLY AND ENTER ITS PREMISES. I FURTHER AGREE TO WAIVE AND RELEASE ANY CLAIMS AGAINST, AND NOT TO SUE, CAMP DRAGONFLY, ITS PRINCIPALS, OFFICERS DIRECTORS, SHAREHOLDERS, AGENTS, EMPLOYEES, AND/OR VOLUNTEERS IN CONNECTION WITH ANY EXPOSURE, INFECTION, CONTRACTION, AND/OR SPREAD OF COVID-19 RELATED TO CAMP DRAGONFLY'S SERVICES AND PREMISES.

I accept that this agreement cannot be orally or otherwise modified. I hereby agree and acknowledge that any claim or dispute arising from or related to the Acknowledgment of Risk, Waiver and Release of Liability granted herein or the relationship of the parties in any respect thereto shall be brought within twelve (12) months of any occurrence or discovery for forever waived) and shall be settled only by mediation or, if necessary to resolve the dispute, legally binding arbitration. Judgment upon mediation or arbitration award may be entered in any Court otherwise having jurisdiction and such mediation or arbitration is the sole remedy and is non-appealable.

THE UNDERSIGNED HAS READ THE ABOVE ACKNOWLEDGMENT OF RISK WAIVER AND RELEASE OF LIABILITY UNDERSTANDS THAT HE/SHE HAS GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND IS SIGNING IT VOLUNTARILY.

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Camper’s Name _____ Date _____

Camper Name: _____

PHOTOGRAPH AND PUBLICITY RELEASE FORM

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 Pennsylvania staff permission and supervision, the news media may wish to photograph, videotape and/or interview the volunteers and children attending camp. This release provides authorization for Camp Dragonfly and Hospice of Central Pennsylvania to use such information as below:

I give Camp Dragonfly and Hospice of Central Pennsylvania permission to use my child's name, likeness, image, voice, and/or appearance, as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, and the like, take or made on behalf of Camp Dragonfly or Hospice of Central Pennsylvania. I agree that Camp Dragonfly and Hospice of Central Pennsylvania have complete ownership of such pictures, etc., including the entire copyright and may use them for any purpose consistent with the Camp dragonfly and Hospice of Central Pennsylvania missions. These uses include, but are not limited to, illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium now known or later developed, including the internet. I acknowledge that I will not receive any compensation for the use of such pictures, etc. and hereby release Camp Dragonfly and Hospice of Central Pennsylvania and its agents, employees and assigns from any and all claims which arise out of or in any way connected with such use.

I have read and understood this content and release.

I give my consent to Camp Dragonfly and Hospice of Central Pennsylvania to use my child's name and likeness to promote Camp Dragonfly and Hospice of Central Pennsylvania, its programs and/or its activities.

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Camper's Name _____ Date _____

(Complete back of this form if you DO NOT want to give Consent)

I do not give my consent to Camp Dragonfly and Hospice of Central Pennsylvania to use my child's name and likeness to promote Camp Dragonfly and Hospice of Central Pennsylvania, its programs and/or its activities.

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Camper's Name _____ 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/shorts – **note: long pants are required for horseback riding**
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.

hcp | Hospice of Central PA

PATIENT DISCLOSURE AUTHORIZATION

Patient Name_____ MR #_____

Birth Date_____ Address_____

Home Telephone_____ Work Telephone_____ Email_____

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

I Authorize the Following Health Information to be Used and/or Disclosed

to determine child's understanding of the death and reactions

I Authorize the Following Person(s)/Organization(s) to Use and/or Disclose My Health Information

Name of counselor:

Phone number of counselor:

I Authorize the Following Person(s)/Organization(s) to Receive and/or Use My Health Information

HCP Journey Program

I Authorize My Health Information to Be Used and/or Disclosed for the Following Purpose(s)

coordination of support for Camp Dragonfly

My Right to Revoke This Authorization. I understand that I have the right to revoke this authorization in writing at any time. To obtain a copy of an authorization revocation form I will contact HCP's Privacy Officer, 1320 Linglestown Road, Harrisburg, PA 17110 or call (717) 732-1000. I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.

Re-disclosure of My Health Information I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may re-disclose my health information without obtaining my authorization.

Disclosure of Direct or Indirect Remuneration Received By Any Person and/or Organization Authorized to Use and/or Disclose My Health Information I understand that the person(s) and/or organization(s) listed below will be receiving direct or indirect remuneration in connection with the use and/or disclosure of my health information.

Expiration of Authorization This authorization will be effective until the following date or event:

June 12, 2024

Patient or Authorized Representative Signature Date

Patient unable to sign because *patient is a minor*

Relationship of Authorized Representative to Patient

HCP Representative Signature Date