



Dear Parent or Guardian of Potential Camp Erin Participant:

Camp Erin is a special camp for children and teens ages 6-17 that have lost someone close to them. The camp is free of charge and is a weekend long event, combining grief support and emotional counseling. Structured games, music, art, stories, and other therapies teach bereaved campers about grief and how to understand their feelings. With support from professionally trained staff and volunteers, children share their experiences and gain valuable skills that help them through the healing process while also having the chance to interact with their peers also coping with loss. The children are referred to Camp Erin through a variety of sources including: hospices, schools, churches, counselors, and agencies serving children and their families.

Once your application has been received, The Spencer Hospice Foundation will interview the children and their guardians, prior to camp, to verify they are appropriate for this camp experience. During the interview, we explain the purpose and premise of the program so families are prepared to participate. In addition, we offer specially designed sessions for parents, which provide skills to strengthen their understanding of how to be an effective support system for their children.

Camp Erin is made possible through a partnership between The Spencer Hospice Foundation and The Moyer Foundation. The Spencer Hospice Foundation is an Orange County based non-profit dedicated to enhancing the quality of life for terminally ill patients and their families. The Moyer Foundation is non-profit organization founded by World Series champion, All-Star MLB pitcher Jamie Moyer and his wife, Karen with a mission of helping children in distress.

Camp Erin Orange County will be held **July 8-11<sup>th</sup>, 2011** at the Irvine Ranch Outdoor Education Center in the city of Orange.

#### Things You Should Know:

- We will process applications as they are received, so you are encouraged to return your application as soon as possible
- Prospective campers are required to attend an assessment meeting by the Spencer Hospice Foundation to determine the child's suitability to attend the camp
- We do maintain a waiting list for all applicants
- Please feel free to contact Craig Strenger at (888) 469-1581 or email him at [cstrenger@spencer-foundation.org](mailto:cstrenger@spencer-foundation.org) if you have questions or need assistance completing the application

#### Application Checklist:

- Applicant is between the ages of 6-17 at the time of camp
- Keep a copy of your completed application for your records
- Return your completed application **by fax to (714) 597- 8275** or mail it to the  
Spencer Hospice Foundation  
3401 W. Sunflower Ave, Ste. 125  
Santa Ana, CA 92704

Sincerely, The Spencer Hospice Foundation



## **CAMP ERIN, ORANGE COUNTY APPLICATION:** **CAMPER INFORMATION**

CHILD'S NAME: \_\_\_\_\_ NICK Name (if preferred) \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Gender:  M  F Parent's Email: \_\_\_\_\_

Parent's name: \_\_\_\_\_ Guardian's name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/Zip Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Contact person and phone number in case of an emergency (Name & Number):  
\_\_\_\_\_

Has your child ever:

Attended day camp?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Attended overnight camp?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spent the night away from home	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is your child a swimmer?  Yes  No

**If yes, indicate level:**  Beginner  Intermediate  Advanced

Does your child:

Enjoy Music?	<input type="checkbox"/> If yes, what kind _____
Play an instrument?	<input type="checkbox"/> If yes, what kind _____
Enjoy/Play Sports?	<input type="checkbox"/> If yes, what kind _____
Enjoy Arts/Crafts?	<input type="checkbox"/> If yes, what kind _____

What is your child's favorite food (s)? \_\_\_\_\_

What is your child's least favorite food (s)? \_\_\_\_\_

Please list any special interest/hobbies your child has: \_\_\_\_\_  
\_\_\_\_\_





## MEDICAL INFORMATION

Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Does your child have any of the following:	Yes	No
Physical Limitations	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Dietary Restrictions (i.e. physician recommended, religious etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions / Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Wears Glasses / Contacts	<input type="checkbox"/>	<input type="checkbox"/>
Recurring headaches or stomach aches	<input type="checkbox"/>	<input type="checkbox"/>
Other: (please specify)	<input type="checkbox"/>	<input type="checkbox"/>
Is your child currently under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
<b>If yes</b> , Physician's Name _____ Phone # _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any allergies? (i.e. food, medicine, or other)	<input type="checkbox"/>	<input type="checkbox"/>
<b>If yes</b> , please explain _____	<input type="checkbox"/>	<input type="checkbox"/>
Any history of operations or serious illnesses?	<input type="checkbox"/>	<input type="checkbox"/>
Will your child be taking medications at camp?	<input type="checkbox"/>	<input type="checkbox"/>
<b>If yes</b> , what are the medications treating? _____	<input type="checkbox"/>	<input type="checkbox"/>
What is the date of your child's latest Tetanus shot?	<input type="checkbox"/>	<input type="checkbox"/>

**REQUIRED INFORMATION:**

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

Is there a hospital that your insurance mandates? \_\_\_\_\_

HOSPITAL OF CHOICE: \_\_\_\_\_

Name of Preferred doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Identification # \_\_\_\_\_ Group: \_\_\_\_\_



## BEREAVEMENT HISTORY

Please include as many details as possible when answering the following questions. We understand that answering some of these questions might be difficult; however, we want to be able to provide the best possible care for your child.

Child's Name \_\_\_\_\_

1. Full name of deceased \_\_\_\_\_ Relationship to child \_\_\_\_\_

2. Birth date of deceased \_\_\_\_\_ Date of death \_\_\_\_\_

3. Age of deceased at time of death \_\_\_\_\_ Age of child at time of death \_\_\_\_\_

4. Was the deceased receiving Hospice Services at the time of death? \_\_\_\_\_

5. Was the death anticipated or sudden? \_\_\_\_\_

6. What was the deceased's cause of death? \_\_\_\_\_

7. Please check if either of the following statements are true:

Child/Adolescent has not been told the facts about the deceased's cause of death

Child/Adolescent does not understand the facts about the deceased's cause of death

If either is checked, please explain:

\_\_\_\_\_  
\_\_\_\_\_

8. Is this your child's first experience with death? \_\_\_\_\_

If no, please comment on other deaths your child has experienced.

\_\_\_\_\_  
\_\_\_\_\_

9. Where did this person die? \_\_\_\_\_

Was the child present at the time of death? \_\_\_\_\_

10. Did the child see the deceased after the death? \_\_\_\_\_

11. Was there a funeral or memorial service? \_\_\_\_\_



If yes, did your child attend and what were your child's comments/reactions to the service?

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12. Did the child live with the deceased? \_\_\_\_\_

13. How would you describe your child's relationship with the deceased?

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14. How would you describe your family's communication style regarding the death?

- Open  Adequate  Very little  Avoided  None

15. Does your child speak openly of the person who died? \_\_\_\_\_

16. Please explain how your child indicates that he/she is grieving. \_\_\_\_\_

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## REACTION TO THE LOSS

Please place an "X" if your child has exhibited any of the following since the death of the loved one:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Lack of energy                                       | <input type="checkbox"/> Behavior problems at school                 | <input type="checkbox"/> Peer difficulties                         |
| <input type="checkbox"/> Withdrawn/Isolation                                  | <input type="checkbox"/> Behavior problems at home                   | <input type="checkbox"/> Drug/Alcohol Use                          |
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Running away from home                      | <input type="checkbox"/> Causing harm to others                    |
| <input type="checkbox"/> Suicidal thoughts/talk                               | <input type="checkbox"/> Headaches, stomachaches                     | <input type="checkbox"/> Lying                                     |
| <input type="checkbox"/> Difficulty with concentration                        | <input type="checkbox"/> Sleeping disturbances                       | <input type="checkbox"/> Stealing                                  |
| <input type="checkbox"/> Causing harm to self                                 | (Please circle: Sleep Walking, Bedwetting, Nightmares, Night Sweats) | <input type="checkbox"/> Destruction of property                   |
| <input type="checkbox"/> Loss of interest in usual activities                 | <input type="checkbox"/> Belief that death was his/her fault         | <input type="checkbox"/> Anger                                     |
| <input type="checkbox"/> Inappropriate sexual behavior                        | <input type="checkbox"/> Belief that death is a punishment           | <input type="checkbox"/> Disbelief                                 |
| <input type="checkbox"/> Special fears  | <input type="checkbox"/> Changes in attendance at school             | <input type="checkbox"/> Always trying to be in control or perfect |
| <input type="checkbox"/> Sadness  | (Please circle: Increase/Decrease)                                   | <input type="checkbox"/> Changes in how he/she feels about self    |
| <input type="checkbox"/> Worries about his/her safety or the safety of others | <input type="checkbox"/> Changes in weight                           |  |
| <input type="checkbox"/> Hyperactive/Impulsive                                | (Please circle: Increase/Decrease)                                   |  |



## OTHER IMPORTANT INFORMATION

1. Has your child received any professional support (i.e. school counselor, mental health therapist, peer support group, psychiatrist, pastoral support)? \_\_\_\_\_

If yes, is support currently provided? Please give approximate dates of when support started/ended.

\_\_\_\_\_

2. Has there been any other changes/stresses in your child's life (i.e. illness, relocation, divorce, remarriage, finances, change of schools, other losses)? Please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Has your child ever experienced abuse of any kind?  Yes  No

If yes, please explain

\_\_\_\_\_

\_\_\_\_\_

4. Are there any language, disability, and/or religious needs that we should be aware of to better serve your child? \_\_\_\_\_

(This information is voluntary and will only be used to help your child with the grieving process).

5. Are there any other special needs, family customs, or cultural aspects to your child's grieving that we should be aware of?

\_\_\_\_\_

\_\_\_\_\_

6. Is your child displaying any behaviors/moods that have you concerned?  Yes  No

If yes, please explain: \_\_\_\_\_

Signature

Date

Relationship to child