Camp Lily Welle

24th Annual Children's Grief & Loss Camp

REGISTRATION AND CONSENT FORM

Saturday, April 2nd, 2022 10:00a.m. – 3 p.m. (Ages 5–13)

Statesboro First Baptist Church

PLEASE **PRINT** INFORMATION

Child's Name: _____ **Gender**: ____Male ____Female

Birth Date: _____ **AGE:** _____

Child's T-Shirt Size *(Please circle one)*: **Adult(A)** AXL AL AM AS **Youth(Y)** YL YM YS

Parent/Guardian Full Name: _____

Address: _____ **City:** _____ **Zip:** _____

CELL PHONE #: _____ **HOME PHONE:** _____

Parents & Guardians are encouraged to attend the Closing Celebration at 2:30p.m.

If you are unable to pick up your child, please list the names and phone numbers to whom your child can be released:

1._____ 2._____

If Parent(s)/Guardian(s) cannot be reached in case of an emergency, contact:

1._____ Phone: _____

2._____ Phone: _____

Is this the *first* year the child has attended our grief camp? _____Yes _____No

Does your child have a religious affiliation? ____Yes ____No Religious Preference: _____

Please describe your child's experience with the death of his/her loved one (who, when, circumstances, adjustment concerns):

_____

_____

I give my permission for child listed above to attend this camp, and I will arrange for him/her to be transported to and from this activity. I give permission for the above named child's photo to be used in publications and newspaper articles pertaining to Ogeechee Area Hospice promotion. ____**YES** ____**NO**

_____ _____

Signature of Parent or Guardian Date

Registration and Health Forms are due by March 4th, 2022

Please submit completed forms through mail or via email to:
Ogeechee Area Hospice ATTN: Tammy Horton, Bereavement Coordinator
P.O. Box 531 Statesboro, GA 30459
thorton@oahospice.org

Ogeechee Area Hospice is a non-profit agency, is Medicare/Medicaid certified, and cares for patients regardless of the ability to pay. GA # 016-057-H

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Health Form

If it is necessary for your child to receive prescription medication while attending Camp Lily Welle, the **medication MUST be delivered to the designated Camp Lily Welle staff member by the parent/guardian on the day of camp in the original container and labeled clearly with the child's name.** The parent/guardian will be required to complete the Authorization for Medication Administration Form. Medication will be given only as directed on the label.

In case of illness/injury, Camp Lily Welle staff will render first aid while contacting the parent/guardian. If the parent/guardian or designee cannot be reached and the situation is serious, the Camp Lily Welle staff will telephone Bulloch County Emergency Medical Services (911) for immediate transportation to East Georgia Regional Medical Center. Fees for transportation and medical services will be the responsibility of the Parent/Guardian.

Insurance Company: _____ Policy #: _____
Doctor's Name: _____ Telephone: _____
Dentist's Name: _____ Telephone: _____

Does your child have any of the following conditions?

_____ Asthma _____Bleeding Disorder _____ Cystic Fibrosis
_____ Diabetes _____Fainting Spells _____ Heart Conditions
_____ Hypoglycemia _____Physical Disability _____Sickle Cell Anemia
_____ Seizures

Allergies: ____None

____Food:(specific food)_____
____Bee Stings ____Medications
____Other: (Specify)_____

Please provide reactions and how to treat_____

_____

Are there any physical, psychiatric, behavioral, emotional, or developmental concerns that the Camp Lily Welle staff should be aware? ____YES ____NO
If yes, please explain_____
_____

I have read and understand the explanations and requests for information in this Health Form. My answers to the questions concerning my child's health are true and correct to the best of my knowledge. I will adhere to the prescription medicine directives and agree for my child to be subject to the illness/injury procedures while at the camp.

Parent/Guardian Signature: _____ **Relationship:** _____

Date: _____ **COMMENTS:** _____

_____

Camp Lily Welle
Authorization for Medication Administration

Child's Name: _____Date of Birth: _____

Doctor's Name_____

Medication :(Name &Dosage) _____

Time(s) to be administered at camp: _____

Time & Date medication last given before arriving to camp: _____

I request and authorize employees of the Ogeechee Area Hospice to administer the above named medication to my child during **Camp Lily Welle on April 2nd, 2022**. I release Ogeechee Area Hospice and its employees, agents or representatives from any liability or responsibility for any illness or damage to any person or property, which may result from the storage of medication, from administering the medication or from failing to administer the medication.

Parent/Guardian Signature: _____Date:_____

Emergency Phone Number: _____

Documentation of Medication Administration (*to be completed by Hospice Nurse*):

Medication Name & Dosage: _____

Time administered: _____

Administered by: _____

Medication returned to Parent/Guardian:

Date & Time: _____

Returned by: _____

Parent/Guardian signature: _____

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