Camp Good Grief

Application

Help us get to know you...
(To be completed by the Parent/Legal Guardian)

Camper's Legal Name: _____ Nickname: _____
Date of Birth: _____ Age:_____ Sex: Male___ Female___
Location of Camp:_____ Grade: _____

Camper's T-Shirt size is: Adult S___M___ L___ XL___ Other:_____

Parent/Legal Guardian: _____
Relationship to Camper: _____
Street Address: _____ City:_____ State:_____ Zip:_____
Home Number: _____ Work Number: _____

MEDICAL HISTORY:
Emergency Contact: _____ Phone Number: _____
Alternate Emergency Contact: _____ Phone Number: _____
Known Allergies: _____
Current Medications:_____
Does the Camper need medication during camp? YES___NO___ If "yes" explain:_____
_____
_____
Previous Injuries: _____
Current Injuries: _____
Other relevant medical history: _____
_____
_____

How do you think this camp would benefit your child?
_____
_____
_____
_____
_____

INFORMED CONSENT:
I hereby grant permission for my child _____ (camper's name) to attend Mountain Hospice Camp Good Grief. I understand that Mountain Hospice Camp Good Grief is a camp designed to help facilitate the bereavement process of my child and provide support for expressing feelings of grief.

Signature of Parent/Guardian: _____ Date: _____

PARENT/GUARDIAN AGREEMENT:
I understand that all reasonable precautions have been taken to insure that all programs and activities are conducted in a safe and responsible manner at Mountain Hospice Camp Good Grief. I understand and accept that my child _____ (camper's name) may be exposed to potential hazards while at Mountain Hospice Camp Good Grief and participating in the activities including but not limited to the natural setting of the camp, activity sites, weather changes, plants and insects.

Signature of Parent/Guardian: _____ Date: _____

WAIVER AND RELEASE OF LIABILITY:
As parent guardian of _____(camper's name), I agree that I will not hold Mountain Hospice, its employees, officers, directors, volunteers, agents and contractors including Camp Good Grief site locations liable for any personal injury, property damage, loss or insurance. I agree to release and hold harmless Mountain Hospice, its employees, officers, directors, volunteers, agents and contractors including Camp Good Grief site locations from all liability incurred as a result of my child's participation in camp and that these terms serve as a release for myself and members of my family as well.

Signature of Parent/Guardian: _____ Date: _____

AUTHORIZATION AND CONSENT TO TREAT A MINOR:
I give permission and authorize Mountain Hospice staff/designees to provide my child _____ (camper's name) routine health care, first aid, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests and ordering injections and/or surgery. I agree to the release of any records necessary for insurance purposes. I give permission to Mountain Hospice to arrange necessary related transportation for the camper. In the event I cannot be reached in an emergency, I hereby give permission to the physician, dentist, or other health care provider selected by Mountain Hospice to secure and administer treatment, including hospitalization for the camper and acknowledge that I will be responsible for the payment of all charges related to the health care services. Please list medical restriction below if any:_____
_____

Signature of Parent/Guardian: _____ Date: _____

PARENTAL AUTHORIZATION:
I authorize and request Mountain Hospice nurse to administer the medication and/or medications prescribed by our family physician and in doing so relieve Mountain Hospice, its agents, employees or representatives of any responsibility for ill effects which may result from administering of said medication.

Signature of Parent/Guardian: _____ Date: _____

Authorization - Use or Disclose PHI - Testimonials, Photos, Social Media

Date: _____

Name: _____

Birth Date: _____ Last 4 Numbers Social Security # | | | | |

With your permission and authorization, we may use your information in printed materials, on our website, on social media we create, and we may release it to the media. Please understand this may involve the use or disclosure of information protected by federal health privacy law that requires your authorization first. We will use or disclose only information you authorize. This form explains your authorization. Please use it to authorize Mountain Hospice to use or disclose your information.

Authorization

I authorize Mountain Hospice to use and disclose information described in Section 1 of this form to publish information, a testimonial or comment about my experience or care I have received. My authorization to use my information extends to any persons working on behalf of Mountain Hospice to create or maintain materials in any format that may include my information, testimonial or comment including but not limited to printed materials, websites and social media. I authorize Mountain Hospice to respond to any comment or testimonial I provide to the extent that its response does not use or disclose any protected health information other than the information described in this authorization.

1. Description of information to be used or disclosed

   For your convenience you may check one or more boxes describing information to be used or disclosed in your comment or testimonial.

   ☐ my photograph ☐ my name ☐ my initials only

   ☐ a comment I write ☐ recording (video or audio) of me

   ☐ my story – written by or for me

   ☐ any other information described in the box below

2. Purpose

   The purpose of this Authorization is to permit Mountain Hospice to use or disclose the information described in Section 1 for public relations and marketing purposes by publication in any medium it creates or is created on its behalf including but not limited to its website, social media, social media website, newsletters, printed materials and press releases. Mountain Hospice will not receive any payment or financial remuneration from anyone for use or disclosure of this information.

3. Expiration Date of this Authorization
   This authorization shall be valid - unless I revoke it earlier in writing - for ten (10) years following the date of the authorization.

I understand

1. I may revoke this authorization at any time by giving Mountain Hospice notice of my revocation in writing.
2. My revocation of this authorization will not apply to information used or disclosed as permitted by this authorization before I give Mountain Hospice written notice of my revocation.
3. Mountain Hospice may not condition my treatment or payment, enrollment or eligibility for benefits on whether I sign this authorization.
4. Information disclosed as permitted by this authorization may be re-disclosed by persons who receive it and is no longer protected by federal health information privacy law.
5. I have a right to request and receive a copy of this authorization.
6. I will not receive any payment or financial remuneration for the information I am authorizing Mountain Hospice to use and disclose by this authorization.

I understand this Authorization to Use or Disclose Protected Health Information for Testimonials and Social Media, signed it voluntarily and received a copy.

Signature, Individual/ Personal Representative _____

Name, Personal Representative (if any) _____

Personal Representative's Authority to Act _____

☐ Identity of the Individual verified

or

☐ Identity, Authority to Act of Personal Representative verified

Received and confirmed for Mountain Hospice by:

_____

Signature Printed Name and Title

Return completed application to the home office:

Camp Good Grief
Mountain Hospice
1002 South Crim Ave
Belington, WV 26250
1-888-763-7789