Hospice Of Lake Cumberland

Camp Promise

Providing support, fun, reflection and the promise of healing to grieving children and adolescents

June 7th-9th, 2019

Return Application Forms to:

Hospice of Lake Cumberland
Bereavement Department
100 Parkway Dr
Somerset KY, 42503
Fax: 606-678-0191
Phone: 1-800-937-9596
Email: salvarez@hospicelc.org

DEADLINE FOR APPLICATION IS May 17, 2019.

Updated 3/25/19

Camper's Full Name: _____

Date:_____

Camper's Name: _____ Home Phone:_____

Address: _____ Cell Phone:_____

City:_____ State:_____ Zip:_____

Gender: _____ Referred By: _____

Has your child attended Camp Promise in the past? □ Yes □ No

What does your child prefer to be called:_____ **(Please print-**for use on name badge)

Date of Birth: ____/_____/_____ Age: _____ School attends: _____

T-Shirt Size: _____ (indicate if youth or adult size please. example: "Medium –Youth")

Mother's/Guardian's Name_____

Day Phone_____ Evening Phone_____ Cell Phone_____

Father's/Guardian's Name_____

Day Phone_____ Evening Phone_____ Cell Phone_____

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

Name_____

Day Phone_____ Evening Phone_____ Cell Phone_____

Name_____

Day Phone_____ Evening Phone_____ Cell Phone_____

Parent email address:_____

Name of the person who died:_____

Their relationship to your child: _____ Date of death:_____

Was this person a Hospice patient? □ Yes □ No

Nature of death: □ Illness □ Accident □ Homicide □ Suicide

Please state your reason for wanting your child to attend camp: _____

_____

Has your child received any professional support since the illness/death? □ Yes □ No

Please note any other recent losses, changes, stressors in your child's life (i.e. divorce, illness, move, finances) or other important things you feel we should know about your child:

_____

_____

_____

Camper's Full Name: _____

HEALTH HISTORY (check those that apply)

___Asthma
___Convulsions/seizures
___Constipation
___Diabetes
___Emotional Problems
___Fainting
___Heart disease
___Menstrual cramps
___Nose bleeds
___Special dietary needs
___Wears glasses
___Other_____

___Ear infections
___Epilepsy
___Hearing impairment
___Kidney disease
___Motion sickness
___Sickle cell anemia
___Wears contact lenses
___Allergies to
  ___Food
  ___Animals
  ___Medicines
  ___Other_____

Please explain any "checked" answers from last question. Indicate any information useful to the adult in charge in relation to any of the health conditions. Also indicate any activities to be encouraged or restricted.

_____

_____

_____

_____

_____

_____

MEDICATIONS*:*
Please list current medications prescribed for your child to take while at Camp Promise, dosage and the purpose of each.

	Name of Medication	Dosage	Purpose
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

List date of child's last Tetanus Injection:_____

I give permission to the camp nurse to administer prescriptions, over the counter medications, first aid and/or access to medical treatment if needed to/for my child.

_____ _____
Signature of Parent/Guardian Date

Camper's Full Name: _____

INFORMED CONSENT AND INDEMNIFICATION AGREEMENT

1. We/I, _____, hereby give permission for our/my child, _____ to be transported and to attend Camp Promise/Camp Jabez on _____. We/I understand that the camp's goal is to help facilitate the bereavement process of our/my child and provide support for him/her in expressing feelings of grief.

2. In consideration of the above-named child being granted permission by Hospice of Lake Cumberland to attend Camp Promise/Camp Jabez,

   WE/I, FOR OURSELVES/MYSELF AND ON BEHALF OF OUR/MY CHILD, RELEASE AND DISCHARGE HOSPICE OF LAKE CUMBERLAND, AND THEIR AGENTS, EMPLOYEES, VOLUNTEERS, OFFICERS, DIRECTORS, SUCCESSORS, AND ASSIGNS (HEREINAFTER COLLECTIVELY "HOSPICE") FROM ALL CLAIMS, DEMANDS, ACTIONS AND JUDGEMENTS WHICH WE/I OR OUR/MY CHILD EVER HAD OR NOW HAS OR MAY HAVE AGAINST HOSPICE FOR ALL PERSONAL INJURIES, EITHER PHYSICAL OR EMOTIONAL, KNOWN OR UNKNOWN, AND INJURY TO PROPERTY, REAL OR PERSONAL, SUSTAINED BY OUR CHILD'S PERSON OR PROPERTY DURING HIS OR HER ATTENDANCE OF CAMP PROMISE/CAMP JABEZ COMBINED CAMP, WHETHER THE INJURY IS CAUSED BY NEGLIGENCE OR ANY OTHER FAULT.

3. Also, in consideration of the above-named child/children being granted permission by Hospice of Lake Cumberland to attend Camp Promise/Camp Jabez:

   WE/I AGREE, JOINTLY AND SEVERALLY TO INDEMNIFY AND HOLD HARMLESS HOSPICE FOR ANY AND ALL CLAIMS, DEMAND, ACTIONS, AND JUDGMENTS WHATSOEVER OF EVERY NAME AND NATURE, BOTH IN LAW AND EQUITY, WHICH OUR/MY CHILD EVER HAD OR NOW HAS OR MAY HAVE AGAINST HOSPICE FOR ALL PERSONAL INJURIES, EITHER PHYSICAL OR EMOTIONAL, KNOWN OR UNKNOWN, AND INJURY TO PROPERTY, REAL OR PERSONAL, SUSTAINED BY OUR/MY CHILD'S PERSON OR BUT NOT LIMITED TO, INJURY CAUSED BY OR ARISING FROM HOSPICE'S OWN NEGLIGENCE.

We, the undersigned, have read this release and understand all of its terms.

DATE:_____ _____
Parent/Guardian Signature

DATE:_____ _____
Parent/Guardian Signature

HOSPICE OF LAKE CUMBERLAND
AUTHORIZATION FORM

Child Name: _____

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below, whom 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.

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

( ) Photograph

( ) Interview (audiotaped and/or videotaped)

( ) Interview (for written publication)

( ) Name

( ) Name in reference to being in the Hospice program

( ) Written work(s)

( ) Artwork

( ) Other: _____

2. I Authorize the Following Persons/Organizations to Use and/or Disclose My Information.

Hospice of Lake Cumberland

Camp Jabez

3. My Right to Revoke This Authorization. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form, I may contact the Director of Information Management Systems/Privacy Officer at Hospice of Lake Cumberland, (606)679-4389. 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.

4. Re-disclosure of My 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.

5. Expiration of Authorization. This authorization will be effective until the following date or event in which Hospice of Lake Cumberland no longer needs photos or information:

_____

HOSPICE OF LAKE CUMBERLAND
AUTHORIZATION FORM

Please complete the following for Minors:

Client is unable to sign because: client is a minor _____

Name of Personal Representative: _____

Authority of Personal Representative (*e.g.,* health care power of attorney, guardian, other statutory authorization): Parent/Guardian

_____

Address: _____

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

_____ _____/_____/_____

Signature of Personal Representative Date

Camper's Full Name: _____

Release of Liability

Camp Jabez OTC, Inc.

I, the undersigned, wish to participate in Camp Promise at Camp Jabez OTC, Inc. I understand that during portions of this event I will be in close proximity to one or more horses under circumstances which may expose me to some risk of injury, because of the nature of horses, the facility, and the activities in which I will be engaged.

In consideration of Camp Jabez OTC, Inc. allowing my participation in this event, I, on behalf of myself, and my heirs, administrators, personal representatives, assigns and children and spouse, if any, do hereby agree to hold harmless, release and discharge Camp Jabez OTC, Inc., which includes its officers, directors, members, agents, representatives, affiliates and insurers, of and from all claims, demands, causes of action and legal liability whether known or unknown, anticipated or unanticipated, due to the ordinary negligence of Camp Jabez OTC, Inc.. I shall not bring any claims, demands, legal actions or causes of action against Camp Jabez OTC, Inc. for any damage or loss due to bodily injury, death or property damage arising out of my participation in this event.

WARNING

Under Kentucky law, a farm animal activity sponsor, farm animal professional or other person does not have the duty to eliminate all risks of injury to the participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities.

_____ _____

Signature of Participant Date

_____ _____

Signature of Parent or Guardian Date
(If participant is a minor.)