Chesapeake Life Center at Hospice of the Chesapeake

Camp Nabi / Phoenix Rising
PROSPECTIVE CAMPER APPLICATION

Camper's Name: _____
Last First Middle

Gender: _____ Age:_____ Birthdate: ____/___/

School Attended: _____Grade & School for Fall 2018: _____

Parent/Legal Guardian: _____

Relationship to Camper: _____

Address: _____

City:_____ State:_____Zip:_____

Home Phone:_____Work Phone: _____Cell Phone:_____

Parent or Guardian's E-mail address:_____

How did you find out about Camp Nabi and Phoenix Rising?_____

What is the name of the special person who died? _____

Age: _____ Relationship to child: _____

Date of death: _____ Cause of death: _____

Age of child at time of death: _____

Where did the person die? ❑ Home ❑ Hospital ❑ Other: _____

Was the person a patient of Hospice of the Chesapeake? ❑ Yes ❑ No

Has the child ever received support services at The Chesapeake Life Center? ❑ Yes ❑ No

Explain the circumstances of the death, the child's reaction and whether the child was present at that time:

Describe the relationship between the child and their loved one who died:

Did the child attend the funeral/memorial service? ❑ Yes ❑ No

If so, describe their reaction to the service:

How would you describe the way your child is grieving?

Has the child spent the night away from home before? □ Yes □ No

Anything else that is important for us to know about the child?

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Camp Nabi / Phoenix Rising
HEALTH HISTORY FORM

Child's Name: _____
last *first* *middle*

Health History – check those that apply

- ❑ Asthma
- ❑ Allergies (list) :_____
- ❑ Constipation / diarrhea
- ❑ Convulsions/ seizures
- ❑ Emotional problems
- ❑ Ear infections
- ❑ Fainting
- ❑ Epilepsy
- ❑ Heart disease
- ❑ Hearing impairment
- ❑ Menstrual cramps
- ❑ Kidney disease
- ❑ Nosebleeds
- ❑ Motion sickness
- ❑ Special dietary needs
- ❑ Sickle cell anemia
- ❑ Wears glasses/contacts (circle)
- ❑ ADD/ADHD
- ❑ Recent hospitalization (List dates):_____
- ❑ Previous suicide attempts
- ❑ Bed wetting
- ❑ Other (specify)
- ❑ Mobility challenges

_____

Please list current medications and purpose for medications (those taken daily or on an as needed basis).

_____

_____

Is your child in any group or individual counseling at this time? ❑ Yes ❑ No
If so, for what purpose: _____

Are there any significant medical needs, concerns, or accommodations we should be aware of?

_____

_____

Are there any special dietary considerations or food allergies that we should be aware of?

_____

Parent/Legal Guardian Permission Statement

The health history included in this packet is correct so far as I know, and the person herein described has my permission to participate in all prescribed camp activities except as noted. If she/he appears to be ill, I will not send her/him to the program. I give permission to the Camp Nabi / Phoenix Rising staff to share the information contained in this packet with the volunteer (s) and counselors who will be working with my child. I give permission to administer prescriptions and or first aid to my child and authorize emergency transport to the nearest acute care facility if necessary. _

_____ _____

Signature – please specify if parent or guardian *Date*

Revised 03.30.2018