

Camp Erin Application

Must be completed & signed by guardian

Mail to: Camp Erin, c/o Solace House, 8012 State Line Road, Ste 202, Prairie Village, KS 66208

Primary Guardian Information

1. _____
First Name Last Name
2. _____
Phone Number Cell Home Work
3. _____
Email Address (*Camp communication occurs primarily through email*)
4. _____
Address City State Zip
5. _____
Relationship to Children Applying
6. _____
Emergency Contact Name & Phone Number

ALL Children in Family Applying

1. _____ M F N
Name DOB Age (Sex: male, female, non-binary) Current Grade & School Relationship to Deceased
2. _____ M F N
Name DOB Age Current Grade & School Relationship to Deceased
3. _____ M F N
Name DOB Age Current Grade & School Relationship to Deceased
4. _____ M F N
Name DOB Age Current Grade & School Relationship to Deceased
5. _____ M F N
Name DOB Age Current Grade & School Relationship to Deceased
6. _____ M F N
Name DOB Age Current Grade & School Relationship to Deceased

_____ Date Application Received	Internal Use Only	Status: _____ Attending Camp
_____ Date Notice Sent		_____ Does not meet criteria
_____ Interview Date		_____ Cancelled
_____ Waivers/Forms Signed & Completed		_____ Remains on Waiting List
<input type="checkbox"/> Yes <input type="checkbox"/> No	Attending Camp Picnic	

Grief History

1. Name of person who died: _____
2. Relationship to child: _____
3. Was the deceased a significant caregiver of the camper? Yes No
4. Date of death: _____ 4. Age at death: _____
5. Was the deceased active or retired military? Yes No If yes, what branch: _____
6. Was the deceased on Kansas City Hospice & Palliative Care services? Yes No
7. What was the cause of death? _____

8. Please briefly describe your family's experience during your loved one's illness/death: length of illness, place of death, your children's knowledge/awareness of the situation, etc: _____

9. Was the child present at the time of death? Yes No 10. Was there a funeral/memorial service? Yes No
11. If so, did the child attend the funeral memorial services? Yes No
12. What concerns do you have about you or your children's grief? _____

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

14. What do you hope your children get out of their experience at Camp Erin? _____

Additional

1. Other Life Changes *It is common for grieving families to experience other challenges that make it difficult to cope with grief.* Have you experienced the following?
 Moves Loss of pet Job Loss Job Change Change of school Divorce/separation
 Other deaths Financial difficulties Health Other
Explain: _____

2. Has your family received any additional support? *If checked, approximate dates and/or number of sessions and name of therapist or facility please)*
- a. Solace House individual or group services _____
 - b. Play or art therapy for children _____
 - c. Individual counseling _____
 - d. School counseling _____
 - e. Other _____
3. Religious or spiritual affiliation (optional) _____
4. Ethnicity (optional) White Black or African American American Indian or Alaska Native
 Asian Native Hawaiian or Other Pacific Islander
5. Does your camper qualify for free or reduced lunch? Yes No
6. Are there any family customs or cultural aspects to your child's grieving that we should be aware of? _____

7. Is there anything we should know to better serve your child? _____

Common Reactions to Grief

Behavioral:

Name(s) of person experiencing problem symptom?

When did this symptom begin? Is this a current

_____ <input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Aggression (Verbal & Physical)	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Excessively avoids Reminders (people/places/situations)	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Cannot function without the deceased	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Decline in grades	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Withdrawal/Isolations	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No

Emotional:

When did this symptom begin? Is this a current symptom?

_____ <input type="checkbox"/> Depressed Mood or Intense Sorrow	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Feeling Hopeless/Hard to plan for future	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Often Tearful	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Feelings of Self-worthlessness	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Guilt	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Unable to Feel Positive Emotions	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No

_____ <input type="checkbox"/> Irritability, Bitterness, Anger or Temper Tantrums	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Easily Startled or Frightened	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Constant Yearning/Longing for Deceased	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Experiencing Disbelief/Emotional Numbness	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Issues Separating from Primary Caregiver(s)	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No

Physical:

When did this symptom begin? Is this a current symptom?

_____ <input type="checkbox"/> Change in Diet (Increase/Decrease)	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Fatigue or Loss of Energy	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Other	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No

Relational:

When did this symptom begin? Is this a current symptom?

_____ <input type="checkbox"/> Parenting Issues/Not Responding to Discipline	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Difficult Peer/Family Relationships	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Problems at School	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Not Feeling Connected to Others	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Hard to Trust Others	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No

Cognitive:

When did this symptom begin? Is this a current symptom?

_____ <input type="checkbox"/> Inability to Concentrate/Make Decisions	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Repeated Distressing Dreams/Flashbacks	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Constant Thoughts Around the Event of the Death	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Unable to Accept the Reality of the Death	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Less Interest/Pleasure in Activities	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Excessively Avoid Upsetting Thoughts/Memory/Feelings	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No

Challenges:

When did this symptom begin? Is this a current symptom?

_____ <input type="checkbox"/> Substance Use	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Harm to Self or Others	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Repeated Thoughts of Death/Suicide	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Suicide Attempt/Plan	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ <input type="checkbox"/> Other	<input type="checkbox"/> Before the Death <input type="checkbox"/> After	<input type="checkbox"/> Yes <input type="checkbox"/> No

About Your Child

1.	Name	Interests/hobbies	t-shirt size (please circle 1 per child) Child S M L XL // Adult S M L XL
	_____	_____	Child S M L XL // Adult S M L XL
	_____	_____	Child S M L XL // Adult S M L XL
	_____	_____	Child S M L XL // Adult S M L XL
	_____	_____	Child S M L XL // Adult S M L XL
	_____	_____	Child S M L XL // Adult S M L XL

2. Has your child ever attended day camp? Yes No
3. Has your child ever attended overnight camp? Yes No
4. Has your child spent the night away from home? Yes No
5. Do you have any concerns regarding your child attending an overnight weekend camp? _____

6. Does your child have any concerns regarding attending camp? _____

7. Please indicate your child’s swimming level: Beginner Intermediate Advanced
 - a. Does your child require a lifejacket or flotation device? Yes No
8. Please indicate your child’s horseback riding level: Beginner Intermediate Advanced

Medical

1. Will your child be taking medications at camp Yes No

Child	Medication	Dosage	Frequency	Reason	Time given

2. Allergies or dietary restrictions

- a) Child: _____ Type of allergy: _____ Reaction: _____ EpiPen Yes No
- b) Child: _____ Type of allergy: _____ Reaction: _____ EpiPen Yes No
- c) Child: _____ Type of allergy: _____ Reaction: _____ EpiPen Yes No
- d) Child: _____ Type of allergy: _____ Reaction: _____ EpiPen Yes No

3. Other health concerns or restrictions we should be aware of: _____

4. Date of latest Tetanus shot: _____

5. In case of emergency, we will call contact provided on page 1:

Child's Physician: _____ Number: _____

Additional Emergency Contact: _____ Number: _____

**There is no cost for families for Camp Erin. Applications are processed first come first serve and spaces are limited.
Early application is recommended.**

Please mail completed application to: Camp Erin, c/o Solace House, 8012 State Line Road, Ste 202, Prairie Village, KS 66208

Once we receive your application, we'll be in touch to schedule a camp interview at Solace House with yourself and your child(ren).

Name (printed): _____

Signature: _____

Relationship to camper: _____

Date of application _____

How did you learn about Camp Erin? _____

