CHP HOME CARE & HOSPICE

RAYS OF HOPE CAMP APPLICATION

Children:

Name	Age	Date of Birth	Grade	Male / Female *(circle one)*	Shirt Size (S, M, L, XL, 2X, 3X)
1. _____				M / F	____Adult ___Youth
2. _____				M / F	____Adult ___Youth
3. _____				M / F	____Adult ___Youth
4. _____				M / F	____Adult ___Youth

Parent/Legal Guardian: _____

Address: _____

Telephone: Cell: _____ Work: _____ Home: _____

Emergency Contact: _____

Address: _____

Telephone: Cell: _____ Work: _____ Home: _____

Family Physician:

Name: _____ Phone: _____

Family Dentist:

Name: _____ Phone: _____

Allergies to foods, stings, medications, etc. (if none, check N/A) ____N/A

List: _____

Special medical problems (if none, check N/A) ____N/A

List: _____

Child needs medications during camp (if none, check N/A)** ____N/A

(upon arrival, all medications will be given to nurse for dispensing)

**Attached physician medication order form needs completed.

Name of prescription: _____

Dose: _____ When to be taken: _____

Name of prescription: _____

Dose: _____ When to be taken: _____

Please list any dietary restrictions: _____

Name of Deceased loved one:_____

Relationship to child/children_____ Date of Death:_____

Describe circumstances surrounding the death:_____

_____

_____

Concerns noted about children's adjustment or issues in the last year:_____

_____

_____

Only _____ or _____is allowed to pick up my child/children at camp.

**COVID-19 precautions will be maintained per CDC guidelines.

Date:_____ Signature of parent/guardian:_____

RAYS OF HOPE
BEREAVEMENT CAMP
WAIVER OF LIABILITY

I, _____, the parent/guardian, hereby give permission for my child _____ to attend "Rays of Hope" Bereavement Camp.

I understand that the camp's goal is to help facilitate the bereavement process of my child and provide support for him/her in expressing feelings of grief.

Photograph & Audiovisual Release

I give permission for my child to be photographed, videotaped or interviewed during "Rays of Hope" Bereavement Camp under staff supervision. This material may be used for publicity of "Rays of Hope" Bereavement Camp including the news media.

Transportation

I also give my permission for the above named child to be transported to any activities involved with this camp and understand that transportation will be provided by staff or volunteers. I understand the child must ride in a car/booster seat until 8 years old or 80 pounds. I release Community Health Professionals, Inc. from any liability related to the transport.

First Aid

I further authorize any representative to administer first aid to the above named child and to be treated in any medical emergency during participation in this camp. Further, the parent/guardian agrees to pay all costs associated with the medical care and transportation for the above named child.

COVID-19

This release includes any injury or death caused by a communicable disease or virus, such as COVID-19. This waiver does not expire. I acknowledge and recognize that Community Health Professionals, Inc. may cancel or suspend "Rays of Hope" Bereavement Camp, if conditions, including but not limited to the rate of COVID-19 in the community warrant.

In consideration of the above named child being granted permission by "Rays of Hope" Bereavement Camp to attend "Rays of Hope" Bereavement Camp, I, for myself and on behalf of my child, release and discharge "Rays of Hope" Bereavement Camp, Community Health Professionals, Inc., its agents, employees, Board of Trustees, Officers, Volunteers, from all claims, demands, actions, judgements, which I or my child ever had or now has or may have against "Rays of Hope" Bereavement Camp for all personal injuries, either physical, or emotional, known or unknown, and injury to property, real or personal, sustained by my child's person or property during his/her negligence or any other fault.

I, the undersigned, have read this release and understand all of the content.

Date:_____ Signature of parent/guardian:_____

CHP HOME CARE & HOSPICE

RAYS OF HOPE
BEREAVEMENT CAMP
PHYSICIAN MEDICATION ORDER FORM

This form is to be filled out by the parent/guardian, signed by the physician ordering medication and returned to "Rays of Hope" Bereavement Camp.

The following medications must be given during camp: Note: the first dose of any new medication must be administered at home.

Name of Camper:_____

Medication/Dosage Time(s) to be given:

1._____

2._____

3._____

Please indicate if medication must be taken with water, milk, food, etc._____

_____

For medications listed above, list all side effects which should be observed by camp personnel.

1._____

2._____

3._____

List any reasons for not giving medications at the prescribed time (vomiting, fever, drowsiness, seizures:

_____

Date:_____ Physician Signature:_____

Address:_____

Phone:_____

Parental Authorization:

I/We authorize "Rays of Hope" Bereavement Camp to administer the medication(s) prescribed by our physician, and in so doing relieve the camp, its agents or representatives of any responsibility for ill effects which may result from the administering of said prescribed medications per the physician directions listed above.

Date:_____ Signature of parent/guardian:_____

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA of Van Wert County

241 W. Main Street • Van Wert, OH 45891
(419) 238-0443 www.vwymca.org

We build strong kids, strong families, strong communities.

GENERAL LIABILITY RELEASE FORM

YMCA Camp Clay

GENERAL LIABILITY:

I understand that the YMCA of Van Wert County/YMCA Camp Clay assumes no responsibility for injuries, which I or my child/ward may sustain as a result of my or my child's/ward's physical condition or resulting from my or my child's/wards participation in any activities, programs, exercise, or the use of any facility, equipment, or other activities organized or sponsored by the YMCA of Van Wert County & Affiliates. I expressly acknowledge that I assume risk for any and all injuries and illness that may result. In consideration of the privilege of joining, or using the YMCA and/or Camp Clay, I hereby voluntarily release and discharge the YMCA of Van Wert County, its agents, servants, and employees from any and all claims of injury, death, loss or damage that I or my child/ward may suffer. I understand that the YMCA of Van Wert County is NOT responsible for personal property lost or stolen while members and/or program participants are using YMCA facilities or on YMCA premises.

Name of Participant_____
Date of Birth_____

Signature_____ Date_____

Address_____ Emergency Contact Number_____
City_____ State_____ Zip_____

Email Address_____

EMERGENCY AUTHORIZATION:

I hereby give permission to the medical personnel selected by the Camp Director to provide routine healthcare; to administer medications; to order X-Rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for myself or my child/ward. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above.

PHOTO RELEASE:

We love taking pictures of our guests enjoying their time at Camp Clay. We often use these photos in our marketing and promotional efforts. By signing this waiver, you agree to give the YMCA of Van Wert County permission to use any media of me or my child at camp for purposes of promoting or interpreting YMCA Programs. If you'd prefer your photo not be used, please let us know in writing prior to your camp experience.

Signature_____ Date_____
Self/Parent/Guardian (circle appropriate title)