Dear Potential Camper Families:

We are excited about your interest in Camp Erin® South Florida!

Camp Erin is a **FREE** overnight weekend bereavement camp for children and teens ages 6 to 17 years old who are grieving the death of a significant person in their lives. Camp Erin combines grief education and emotional support with fun traditional camp activities. Our grief professionals and trained volunteers provide a caring and supportive environment for campers to explore their grief, learn essential coping skills, and make meaningful connections with peers their age who are also grieving.

To register your child(ren) for Camp Erin, please complete the following steps:

1. **SUBMIT CAMPER APPLICATION:** Complete and submit one camper application per child to **CampErin@catholichospice.org**. Please also attach a copy of your child's health insurance card (if applicable).
2. **COMPLETE A FAMILY INTERVIEW:** After receiving your application, a Camp Erin team member will contact you to schedule a Family Interview to review your application(s) and help familiarize your family with our camp program. The interview will also help us to get to know your child(ren) and determine their readiness for camp and if Camp Erin fits their current needs.
3. **ATTEND "SAVE YOUR SPOT" CAMPER ORIENTATION:** "Save Your Spot" is an opportunity for you and your camper(s) to meet our Camp Erin team and other campers, and learn more about what to expect at camp. **Attendance is required and will confirm your child(ren)'s spot at camp.** Details of "Save Your Spot" to follow the Family Interview.
4. **ATTEND CAMP:** Once you have completed the above steps, the only step left is for your child(ren) to attend camp! After attending Camp Erin the first time, campers are able to return ONE time per year.

If you have any questions or need assistance completing your application, please contact our team by phone at **(954) 944-2709** or by e-mail at **CampErin@catholichospice.org**.

All the best,
The Camp Erin South Florida Team

CAMP ERIN
CATHOLIC HOSPICE
PART OF THE ELUNA NETWORK

CAMP ERIN SOUTH FLORIDA CAMPER 2025 APPLICATION

Child's Full Name: _____ **Preferred Name**: _____

Date of Birth (mm/dd/yyyy): _____ **Age**: _____ **T-Shirt Size**: _____

Gender: ☐ Male ☐ Female ☐ Non-Binary **Preferred Pronouns**: _____
(Examples: She/Her/Hers, He/Him/His, They/Them/Theirs)

Child's Mailing Address (Street/City/State/Zip): _____

Race/Ethnicity (Check ALL that apply): ☐ Black/African American ☐ White/Caucasian ☐ Hispanic/Latinx
☐ Asian ☐ Multiracial ☐ Other (please indicate): _____

Has this camper attended Camp Erin before? ☐ Yes ☐ No *If Yes, Year/Location?* _____

Have you talked to your child about the possibility of attending Camp Erin? ☐ Yes ☐ No

Principal concerns and/or what do you hope your child would gain from attending Camp Erin: _____

_____

Please indicate if you will need assistance with transportation. ***(ONLY FOR CAMPS AT CAMP OWAISSA BAUER IN HOMESTEAD)***

☐ **BROWARD BUS**: 4790 N State Road 7, Lauderdale Lakes, FL 33319

☐ **MIAMI BUS**: 14875 NW 77th Avenue, Miami Lakes, FL 33014

☐ **DIRECT**: No, I will not need transportation assistance. I will drop-off and pick-up my camper to/from campsite.

Does anyone in the family have Military Affiliation? ☐ Yes ☐ No *If yes, what branch?* _____

Was the deceased a Significant Caregiver of the camper? ☐ Yes ☐ No

In the last year, did you or anyone in your family qualify for any government assistance programs? ☐ Yes ☐ No

Name of Parent/Legal Guardian: _____ **Relationship to Child**: _____

E-mail (please print clearly): _____

Phone Number: _____ **Is text OK?** ☐ Yes ☐ No **Best Time to Contact**: _____

Emergency Contact Name (other than parent/guardian): _____

Relationship to Child: _____ **Phone Number**: _____

How did you hear about Camp Erin? _____

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CAMPER NAME: _____

CAMPER BEREAVEMENT HISTORY

PLEASE INCLUDE AS MANY DETAILS AS POSSIBLE WHEN ANSWERING THE FOLLOWING QUESTIONS. WE UNDERSTAND THAT ANSWERING SOME OF THESE QUESTIONS MIGHT BE DIFFICULT; HOWEVER, WE WANT TO BE ABLE TO PROVIDE THE BEST POSSIBLE CARE FOR YOUR CHILD.

Full name of deceased: _____ **Relationship to child**: _____

Date of death: _____ **Age of deceased at time of death**: _____

Was the death anticipated or sudden? _____ **Cause of death**: _____

Please describe how the death was explained to the child: _____

_____

How you describe your family's communication style regarding the death? (Check one)

☐ Open ☐ Adequate ☐ Very Little ☐ Avoided ☐ None

Please check if either of the following statements are <u>TRUE</u>:

☐ Child/Adolescent was present at time of death.
☐ Child/Adolescent does not understand the facts about the deceased's cause of death.
☐ Child/Adolescent currently receives professional support. If so, explain: _____
☐ This is not child's first experience with death. If so, explain: _____

Please indicate other factors that might affect child's grief (i.e., changes, illness, relocation, divorce, history of abuse, remarriage, finances, other losses) _____

_____

Please describe how your child indicates that he/she is grieving. Do they speak openly about the person who died? _____

_____

_____

Reaction to Loss: (Check all the behaviors your child has exhibited after the death of their loved one)

☐ Withdrawn/Isolation
☐ Depression/Sadness
☐ Suicidal thoughts/talk
☐ Nightmares
☐ Drug/Alcohol Use
☐ Causing harm to self/others
☐ Anger/Aggressiveness
☐ Crying Spells
☐ Fearful of _____
☐ Believes that death was his/her fault
☐ Believes that death is punishment
☐ Separation Anxiety
☐ Other (please describe): _____

Difficulty with: (Check all that apply) ☐ Energy ☐ Weight ☐ School Attendance ☐ Self-esteem

Describe your child's personality and any special needs (i.e., language, disability, and/or religious needs), family customs, cultural aspects, concerning behaviors/moods that we should be aware of to better serve your child. _____

_____

_____

CONSENT FOR MEDICAL/SURGICAL CARE, EMERGENCY TREATMENT AND MEDICAL INFORMATION FORM

Child's Name: _____ **Date of Birth**: _____

Parent/Guardian Name: _____ **Relationship to Child**: _____

As the parent/legal guardian of the above named child, I give full authorization to Camp Erin® staff or agents to secure medical care or treatment for said youth. This treatment may include assistance from the nearest physician, medical clinic, hospital, trained nurse, EMT, or other health care professional in the event of illness or injury that requires immediate attention as determined by Camp Erin staff. In the event of an emergency and I cannot be contacted, I give permission to the treating medical institution and/or medical providers to render any medically necessary care for my child. I further authorize Camp Erin and its agents to disclose any and all information they deem appropriate and as necessary to secure appropriate care for my child. I agree that I am responsible for any such care rendered to my child and will indemnify and hold harmless Camp Erin for such care or related costs or expenses.

Please describe <u>any health issues and/or problems</u> that you child has (i.e., physical limitations, dietary restrictions, use of corrective lenses (glasses/contacts), significant medical history etc. If none, please write "NONE": _____

_____

_____

List all medications* (prescription/non-prescription) that your child will need to take while at camp:

Name of Medication	Dose	Frequency	Prescribing Physician	Reason for taking

<u>PLEASE BRING MEDICATIONS IN THEIR ORIGINAL CONTAINERS</u>

Please list any allergies (i.e., season, food, medication, and all other allergies) and indicate reactions: _____

_____

_____

Is your child under the care of a Primary Care Physician (PCP)? ☐ Yes ☐ No

Child's PCP Name: _____ Phone Number: _____

Physician Address: _____

Is there a hospital that your insurance mandates? ☐ Yes ☐ No

If yes, what is name and address of hospital of choice: _____

Does your child have medical insurance? ☐ Yes* ☐ No ***IF YES, ATTACH COPY OF HEALTH INSURANCE CARD***

Name of Health Insurance Carrier: _____ Phone Number: _____

Policy Holder's Name: _____ Policy & Group Number: _____

Signature of Policy Holder: _____ Date: _____

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PART OF THE ELUNA NETWORK

CAMPER NAME: _____

CUSTODY RELEASE FORM

Name of Camper: _____

Camper Date of Birth: _____

I am the parent or legal guardian of the child camper identified above. I hereby authorize and direct Camp Erin®, its staff, and/or its volunteers to release the child camper to the following person(s) during or at the end of Camp Erin for purposes of transporting or otherwise assuming custody of the child camper:

Name of Person Authorized: _____

Address (Street/City/State/Zip): _____

_____

Home Phone Number: _____

Cell Phone Number: _____

E-mail: _____

If it is necessary for my child to leave Camp Erin before the end of the program due to illness, injury, or behavioral issues, and I cannot be reached, I hereby give permission for my child to be released into the custody of the person identified above. I understand that Camp Erin may require photo identification of anyone who picks up the child camper from Camp Erin, including myself.

I herby release Camp Erin, its staff, volunteers and representatives from liability for releasing the child camper to the person identified above.

I understand and agree that, in the event of necessary health care or other emergency, Camp Erin may release my child to health care professionals or other appropriate personnel.

I have read and understood this entire form, and I agree to be bound by the conditions of the agreement.

_____ _____

Signature of Parent/Guardian **Date**

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CAMPER NAME: _____

CATHOLIC HOSPICE, INC. PRIVACY RELEASE STATEMENT

I, the undersigned, am guardian of _____ and hereby voluntarily participate and give authorization for the minor child to appear in photographs and/or interviews with respect to Camp Erin® and its activities.

I do hereby consent to the use of the above materials in any form of media (publications, radio, television or internet). I also understand that my identity may be disclosed in connection with the photographs and/or interviews.

I do hereby release, Catholic Hospice, Catholic Health Services, and the Archdiocese of Miami, its agents and employees from all liability in connection with the above. I waive any right to inspect or approve the finished product, the advertising or other copy that may be used in connection with the above.

I hereby consent to the above, without expectation or remuneration to me now or in the future. The agreement shall be binding upon my heirs, personal representatives and assigns.

☐ **Please check here if you DO NOT consent and authorize for your child to appear in photographs and/or interviews with respect to Camp Erin® and its activities.**

_____	_____
Print Name (Parent or Legal Guardian)	**Print Name (Catholic Hospice Rep.)**
_____	_____
Signature of Parent/Legal Guardian	**Signature of Catholic Hospice Rep.**
_____	_____
Date	**Date**