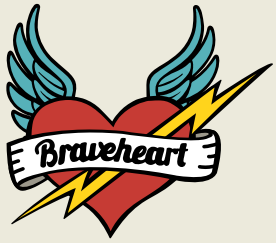
2024 Camp Braveheart Application



**First-time campers will be given priority. Return campers will be placed on a waiting list.*
Please complete a separate application for each child — feel free to photocopy.

Camp for 1st -6th graders will be held June 3-7, 2024

Camper's Name: Nickname:

Date of Birth: Age: Current Grade: Sex: Male Female

Parent/Guardian Name:

Address:

City, State and Zip:

Home/Cell Phone: Work Phone: Email:

T-shirt size: Youth S Youth M Youth L Youth XL Adult S Adult M Adult L Adult XL

Loss Information

Name of Person who died: Relation to Camper:

Was the deceased served by Hospice of NGMC? Yes No Unsure Date of Death:

Circumstances of death (please be specific):

Emergency/Medical Information

Emergency Contact Name: Phone:

If you child has any allergic reactions please list them below:

Allergy: Reaction:

Allergy: Reaction:

Child's Physician: Phone:

Please list any other medical/behavioral or other information camp staff should know about your child:

Persons permitted to pick up my child from camp:

Name: Phone:

Name: Phone:

Please return completed forms to Christina Rijneveld at Christina.Rijneveld@nghs.com.

Questions?

Email griefsupport.hospice@nghs.com
or call 770-219-0276.

Northeast Georgia Medical Center
HOSPICE & IN-HOME PALLIATIVE CARE

Parent/Guardian Agreement

I understand that I will be contacted by hospice grief support staff within two weeks of the receipt of this application by phone in order to confirm my child's registration to provide staff with more in-depth information about my child and the loss and to schedule a Camper Interview with me and my child.

I agree to attend the MANDATORY Camper Interview with my child. I understand that while camp is provided at no cost, my child and I MUST attend this meeting in order for my child to attend camp. If we are unable to attend our scheduled meeting, I must inform Braveheart Staff ASAP to make other arrangements. If we fail to attend this meeting without prior notification of Braveheart Staff, my child's registration will be forfeited.

I understand that first-time campers are given priority. If my child has previously attended Camp Braveheart, he or she will be placed on "first-come, first- served" waiting list. Braveheart Staff will contact me as soon as possible if there is an opening for my child.

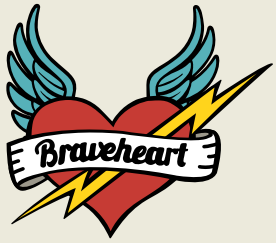
Camp Braveheart is held at Walter's Barn which is located at 7743 Persimmon Tree Rd. Lula GA, 30554. Camp runs from 8:30 a.m. until 3:30 p.m. Monday through Thursday and will conclude with a special session for both campers and family members on Friday from 9 a.m. until 12 noon. Parents/guardians are strongly encouraged to attend. I understand that Camp Braveheart is a "day camp" which means that I, or a designated party, will be responsible for dropping off and picking up my child on a daily basis. Campers should arrive **no earlier than 8:15 a.m. and should be picked up by 3:30 p.m**.

I understand that Camp Braveheart is facilitated by a team of licensed social workers and therapists as well as trained volunteers. There will be a registered nurse available to render first aid. If my child takes medication, it will need to be left with a camp counselor during check-in each morning.

Signature: _____ Date: _____

Printed Name: _____

Pillow Request Form



Hospice of NGMC volunteers will transform a cherished piece of clothing from your loved one into a one-of-a-kind "Memory Pillow" made especially for you. This pillow serves as a meaningful way for you to remember and hold onto memories of that special person. Please provide us with the following information:

Name of Camper:

Name of Deceased:

Detailed Description of Clothing Item:

○ Yes ○ No: I would like any left over buttons returned to me.

○ Yes ○ No: I would like the left over fabric scraps returned to me.

Special Instructions or Requests? Please give details / description.

Every effort will be made to fulfill special requests but it is up to the discretion of the sewing volunteer to determine if the request is possible.

Signature of agreement: Date:

For Office Use Only:

Name of Bereavement Counselor:

Name Of Volunteer Sewing Pillow:

Date garment given to volunteer: Date pillow returned to hospice:

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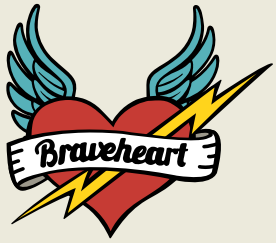
HOSPICE & IN-HOME PALLIATIVE CARE

Authorization for Prescription and Non- Prescription Medication



No medication shall be given by Camp Braveheart nurses without the signed permission of the parent or legal guardian. All medication must be in the original container with the child's name, name of the physician, medication name and medication directions written on the label.

Non-prescription medication can only be dispensed if there is written authorization from the parent or legal guardian to do so. Camp staff will attempt a phone call prior to administration of any non-prescription medication.

Hospice of NGMC reserves the right to use photos of the completed memory pillows for publicity, education, and other hospice activities.

Prescription Medication:

Child's name: _____ Age: _____

Medication name: _____ Time to be given: _____

Medication name: _____ Time to be given: _____

Non-Prescription Medication:

Medication name: _____ Time to be given: _____

Medication name: _____ Time to be given: _____

Camp Braveheart's nursing staff may give my child:

Ibuprofen: ○ Yes ○ No Benadryl: ○ Yes ○ No Basic First Aid Care: ○ Yes ○ No

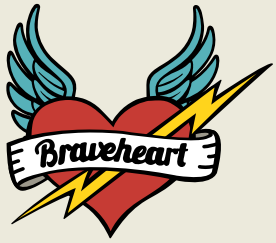
I hereby give permission to dispense the medication(s) listed above in accordance with the written directions on the prescription label or printed on manufacturer's label.

Parent/Guardian Signature: _____ Date: _____

Phone Number: Date: _____

Northeast Georgia Medical Center
HOSPICE & IN-HOME PALLIATIVE CARE

Camper Additional Information Sheet



Camper Name:

Parent/Guardian Name:

Emergency Contact Phone Number:

Alternate Emergency Name and Number:

1. Please tell us a little bit about the person(s) who died, their relationship with the child and the circumstances of their death.

2. Please tell us a little bit about your child's behavior since the death (ex. changes- good or bad, school performance, separation issues, friendships).

3. Please tell about any special needs/issues that your child has that we need to know about such as autism, history of abuse/neglect, mental health diagnosis, IEP, physical limitations and other stressors.

4. Please include any other information about your child's family and friends (ex. recent move, other family members who may be ill, school changes, siblings).

5. Please tell us about your child's strengths.

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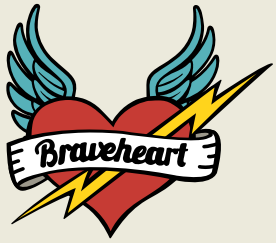
Transportation Waiver



By signing below, I agree to allow my child _____ to participate in the Hospice of Northeast Georgia Medical Center (NGMC) Braveheart Program. I hereby release, absolve and hold harmless NGMC, Walco farms, LLC, Gainesville City School system as well as its representatives, successors and assigns for any and all claims for personal injury, property damage, death or other damages sustained while participating in the Braveheart Program and/or traveling in Gainesville City School vehicle/bus.

The above referenced youth has my permission to be transported by the Gainesville City School system, Braveheart staff/ volunteers or their representatives in approved vehicles. I understand that no transportation will be provided to or from camp/home.

Signature: _____

Date: _____

Northeast Georgia Health System, Inc.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION NOT RELATED TO TREATMENT, PAYMENT, OR OPERATIONS (TPO)

Patient Name: Date of Birth:

Patient Street Address: City:

State: Zip Code:

By signing below, you hereby authorize Northeast Georgia Health System, Inc. to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under the federal privacy rule, for the sole purpose and time period described below. You understand that this authorization is voluntary and you may refuse to sign. Subject to certain exceptions, you have the right to inspect and copy the protected health information to which it refers.

Information to be used or disclosed (must be identified in a specific and meaningful fashion); and include the purpose of the use or disclosure:

Photographs, audio and video interviews, brochures, displays, online content, news articles, etc. for the purpose of bereavement activities, hospice promotional activities and ongoing community outreach

Information that ***may not be used or disclosed:***

Northeast Georgia Health System, Inc. and its specific department or unit Hospice is authorized to make the requested use or disclosure.

Northeast Georgia Health System, Inc. may make the requested use or disclosure to the following person(s) or organization(s):

Northeast Georgia Health System – for the development of materials to promote services of Hospice of NGMC.

Northeast Georgia Health System, Inc. may no longer disclose this information after the following date:

Open ended/ no end date

You have the right to revoke this authorization in writing. Be advised that any revocation cannot apply retroactively to such disclosures. You also have the right to request cessation of the production of recordings, films or other images. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under the federal privacy rule. We will not condition treatment based on your authorization.

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am: