

PERSONAL INFORMATION:

NAME: _____ Girl _____ Boy _____

Date of Birth: _____ Age _____ Grade _____

T-shirt size: Sm _____ Med _____ Large _____

Likes/Dislikes: *Explore the child's favorite likes and dislikes.*

Music: *Song, Type* Instruments Played: *What?* Dance: *Type?*
Comments: _____

Art/Literature: *Type, Drawing, Writing/Story Telling: Genre, Type* Reading: *What?*
Comments: _____

Sports/Games: *Type,*
Comments: _____

Science, Mathematics, Computers, TV/Movies, Nature, History:
Comments: _____

Other Household Members:

Name	Age	Relationship to Child / Adolescent
------	-----	------------------------------------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------

Are Parents / Guardians living at different addresses? Yes _____ No _____

Parent's/ Guardian's contact information:

Name: _____ Email: _____

Phone Number: (H) _____ (W) _____

Address: _____

Name: _____ Email: _____

Phone Number: (H) _____ (W) _____

Address: _____

Emergency Contact (s):

Name: _____ Phone: _____

Name: _____ Phone: _____

Information About Your Loss

Name of person who died: _____ Date of death: _____

Their relationship to the camper: _____ Age of deceased: _____

Describe the child's relationship with the person: _____

Place of death: Home ____ Hospital ____ Other _____

Nature of death: Illness ___ Accident ___ Suicide ___ Homicide ___ Expected _____

Was the child / adolescent a witness of the death? Yes _____ No _____

Did your child attend the memorial / funeral? Yes _____ No _____

Has your child received any professional support since the loss / death? Yes ___ No ___

If 'yes', check all that apply

Hospice Bereavement Care

Family Physician

Minister, Priest, Rabbi, Clergy

Counselor

Other _____

Has your child been told the facts regarding the person's death? Yes ___ No ___

Does your child understand the facts regarding the death? Yes ___ No ___

Please further explain above responses: _____

Are there any other previous deaths?

Relationship	Cause of Death	Date of Death
-----	-----	-----
-----	-----	-----
-----	-----	-----
-----	-----	-----

Are there any other recent losses, changes, stresses in your child's life?

Loss, change or stressor	Effect on child
-----	-----
-----	-----
-----	-----
-----	-----

Have there been any of the following reactions or behaviours in your child?

Feelings / Emotions:

- Expressions of disbelief before after Comments:

- Anger before after Comments:

- Anxious / nervous before after Comments:

- Blaming / punishment before after Comments:

- Suicidal thoughts before after Comments:

- Loneliness / isolation before after Comments:

- Worried about safety 🗿 before 🗿 after Comments:

- Desire to be with deceased 🗿 after Comments:

Behaviours:

- Trying to act 'perfect' 🗿 before 🗿 after Comments:

- Withdrawing 🗿 before 🗿 after Comments:

- Changes in appetite 🗿 before 🗿 after Comments:

- Lack of energy 🗿 before 🗿 after Comments:

- Difficulty concentrating 🗿 before 🗿 after Comments:

- Headaches 🗿 before 🗿 after Comments:

- Stomach aches 🗿 before 🗿 after Comments:

- Sleep disturbances 🗿 before 🗿 after Comments:

- Bedwetting 🗿 before 🗿 after Comments:

- Loss of interest 🗿 before 🗿 after Comments:

- Problems at school 🗿 before 🗿 after Comments:

- Alcohol / drug use 🗿 before 🗿 after Comments:

- Sexual behaviour before after Comments:

- Injuries / accidents before after Comments:

Has your child experienced emotional or mental health issues for which they have received professional help? -----

Which of the following has been helpful to your child?

- talking with a friend writing or drawing talking with family
- physical activity / sports visiting gravesite talking / writing to the deceased
- talking with other supportive persons other -----

Other Important Information

Has your child experienced abuse of any kind? yes no

Does your child have any specific fears or phobias?

Does your child have any special routines that we should be aware of?

Does your child have any physical limitations or restrictions?

Does your child have any dietary limitations or restrictions?

Does your child wear glasses or contact lens? yes no

Is there any other information that we should know to best support your child during their time at Camp Skylark? _____

Consents

The bereavement history is correct to the best of my knowledge.

----- Date: -----
Signature of Parent / Guardian

Print Name

PHOTO & VIDEO CONSENT

✚ *I hereby authorize Camp Skylark to use any photographs taken of my child while participating in the Camp Skylark program for promotional materials including both brochures and websites.*

✚ **DO NOT USE** *any photographs taken of my child while participating in the Camp Skylark program for promotional materials including both brochures and websites.*

FOLLOW UP CONSENT

✚ *I hereby authorize the Fraser Canyon Hospice Society to contact me with additional information about grief and bereavement for children and/or families after Camp Skylark*

✚ *Please do not contact me after Camp Skylark is complete*

----- Date: -----
Signature of Parent / Guardian

Print Name Above

----- Date: -----
Signature of Witness

Print Name