Dear Prospective Camper Family,

Thank you for your interest in Camp Erin®-King County! This year camp will be held at Lake Retreat Camp in Ravensdale, WA from **Friday, June 12th** through **Sunday, June 14th**.

Please complete the enclosed application and return it to our office as soon as possible, as space at camp is limited and applicants are considered on a first-come basis. Also, please note that preference is given to campers who have not attended Camp Erin before. However, a waiting list of applicants whose applications were received after all spots were filled or who have attended camp before, is kept and these applicants will be accepted as space allows during mid-May.

Please be sure to sign and complete the following components of the application packet:

- Camper Application
- Camper Health Form

Then, please mail your application to: 

**Providence Hospice of Seattle**
Attn: Camp Erin Coordinator
2811 South 102nd St., Suite 220
Tukwila, WA 98168-1870

Once we have received and reviewed your application, we will contact you concerning a potential interview with you and your child.

Please feel free to contact me with any additional questions or concerns.

Thank you again for your interest. We look forward to meeting you!

Sincerely,

Nicole Sotkiewicz
Camp Erin Coordinator
Providence Hospice of Seattle
Direct: 206-749-7689
Nicole.Sotkiewicz@providence.org
Camp Erin 2020 King County
Camper Application
Friday, June 12 – Sunday, June 14

Section I. Camper Information (Please fill out a separate registration form for each child)
Child’s Name: __________________________________________ Date of Birth: __________
  Last, First (legal), Middle Initial                   Preferred Name or Nickname
Home Address: __________________________________________
  Street Address                                      City, State, Zip
Mailing Address (if different): ____________________________
  Street Address/PO Box                               City, State, Zip
Age: ______  Current School Grade: ______ Gender: _________ Pronoun Preference: ____________

Section II. Caregiver Information
What is your relationship to the child?  □ Parent        □ Grandparent        □ Other ____________________________
Are you the legal guardian?  □ Yes        □ No (Form must be signed by a legal guardian)
Parent/Guardian Name(s): _________________________________________________________________
Parent/Guardian Phone: Primary: __________________________________ Secondary: ______________
Parent/Guardian Email: _________________________________________________________________
What is the best time/way to reach you?  □ Email        □ Phone Call        □ Other ____________________________
What languages are spoken in the child’s home? ______________________________________________
Who currently lives in the home with the child (list names/ages): ____________________________
____________________________________________________________________________________
Are the child’s guardian(s), parent(s) or deceased a military member or veteran?  □ Yes        □ No
If yes, which branch of the military? ______________________________________________________

Section III. Emergency Contact Information (list two people other than you to contact in case of an emergency)
Emergency Contact #1: __________________________________ Relationship to child: ______________
  Phone: Primary: __________________ Secondary: __________ Other: ____________________________
Emergency Contact #2: __________________________________ Relationship to child: ______________
  Phone: Primary: __________________ Secondary: __________ Other: ____________________________

Child’s T-Shirt Size  □ Youth Small (6-8)  □ Youth Med (8-10)  □ Youth L (10-12)  □ Youth XL (12-14)
□ Adult Small  □ Adult Med  □ Adult Large  □ Adult XL  □ Adult 2X  □ Adult 3X

CE STAFF ONLY
Date received: ____________________
□ Processed  □ Scanned
□ Called  □ Interview Date

Please return application to:
Providence Hospice
Attn: Camp Erin Coordinator
2811 South 102nd St, Suite 220
Tukwila, WA 98168-1870
Section IV. Bereavement History (Please attach an extra sheet if you need more space)

Name of person(s) who died: ____________________________________________
Relationship(s) to child: ____________________________ Was the deceased a primary caregiver of the child? □ Yes □ No
Date(s) of Death: ____________________________________ Age(s) of deceased at time of death: _______________
What was the cause of death(s)? _________________________________________________________________________
Age of child at time of death(s): ________________________
Was the deceased receiving hospice services? □ Yes (specify hospice name): _____________________________ □ No
Was the death anticipated? □ Yes □ No
Did the child live with the deceased at the time of death? □ Yes □ No
Did the child see the deceased after the death? □ Yes □ No
Was the child present at the time of death? □ Yes □ No
Has the child experienced any other death(s)? □ Yes □ No
If yes, please comment on other deaths the child has experienced: ____________________________________________

Did the child attend the funeral/memorial service? □ Yes □ No
If yes, what were the child’s reactions to/comments about the service? ____________________________________________

Did the child have the opportunity to say goodbye to the person before the death? □ Yes □ No
Please provide more detail if applicable: ____________________________________________
Do you and the child talk about the deceased? □ Yes □ No If yes, how openly? _____________________________
Describe the relationship between the child and the deceased (e.g. close, saw on occasion, distant, conflicted): _______
Please describe how the child has reacted to the death or any indications that they are grieving: ____________________________

Is there anything we should know about the child’s understanding of the death? □ Yes □ No
If yes, please describe ____________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Check any/all of the following behaviors the child has exhibited in the past 6 months or that are of concern to you:

☐ Headaches, stomachaches  ☐ Unusual/inappropriate sexual behavior  ☐ Special fears
☐ Intense fears  ☐ Behavior problems at school  ☐ Causing harm to self
☐ Peer difficulties  ☐ Suspension or expulsion  ☐ Causing harm to others
☐ Withdrawal/isolation  ☐ Behavior problems at home  ☐ Suicidal thoughts/talk
☐ Depression  ☐ Running away from home  ☐ Suicide attempt
☐ Destruction of property  ☐ Lying  ☐ Drug/alcohol/tobacco use
☐ Stealing  ☐ Intrusive thoughts or images  ☐ Anxiety when separated from Caregiver
☐ Ongoing sleep disturbances (please circle: sleep walking, bedwetting, nightmares, other): ________________________

Please use this space to provide any additional information for the checked boxes above: ________________________________

Has the child said or done anything specific recently that has concerned you?  ☐ Yes  ☐ No
If yes, please describe: ___________________________________________________________________________________

Have there been other changes/stressors in the child’s life?  ☐ Yes  ☐ No
If yes, check all that apply:
☐ Illness  ☐ Remarriage  ☐ Loss of Friends  ☐ Other: ________________________
☐ Relocation/Move  ☐ Finances  ☐ Change in Caregiver  ☐ Other: ________________________
☐ Divorce  ☐ Loss of Pet  ☐ Change in sleeping arrangements  ☐ Other: ________________________

Please describe: ___________________________________________________________________________________

Has the child received counseling/grief support services before or after the death?  ☐ Yes  ☐ No
If yes, what types? (Please check all that apply)
☐ School Counselor  ☐ Therapist  ☐ Safe Crossings  ☐ Clergy  ☐ Other: ________________________

Is support currently provided?  ☐ Yes  ☐ No

Section V. Camp Information *(Please attach an extra sheet if you need more space.)*

Has your child attended Camp Erin before?  ☐ Yes, when/location ________________________________  ☐ No

Have you and the child talked about them coming to Camp Erin?  ☐ Yes  ☐ No

How does your child feel about coming to camp?  ☐ Looking forward  ☐ Unsure  ☐ Does not want to attend

What, if any, concerns do you have about the child coming to camp? ___________________________________________________________________________________

What, if any, concerns does the child express? ___________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________
Has the child ever:

- Spent a night away from home? ☐ Yes ☐ No
- Attended day camp? ☐ Yes ☐ No
- Attended overnight camp? ☐ Yes ☐ No

Swimming Level:

- ☐ Beginner
- ☐ Intermediate
- ☐ Advanced
- ☐ Does not swim

List any special interests or hobbies the child has: ______________________________________________________
____________________________________________________________________________________________________

What activities or behaviors help the child cope with difficult feelings? ____________________________________________
____________________________________________________________________________________________________

Is there anything we should know about the child’s religious beliefs or faith practice? _______________________________  
____________________________________________________________________________________________________

What else should we know to best support the child? __________________________________________________________
____________________________________________________________________________________________________

How did you hear about Camp Erin? Check all that apply

☐ Hospice ☐ Standing Together ☐ School ☐ Internet ☐ Counselor ☐ Friend ☐ Other: ________________________________

Section VI. Demographics (optional, does not impact the acceptance process)

Race/Ethnicity: Check all that apply:

☐ Asian ☐ African American ☐ American Indian/Alaskan Native ☐ Caucasian
☐ Latino/Hispanic ☐ Pacific Islander ☐ Other _________________

Estimated annual household income where the child resides:

☐ less than $36,375 ☐ $36,376 - 50,000 ☐ $50,000 - 100,000 ☐ over $100,000

Parent/Guardian Signature (must be signed by the legal guardian)

I, the undersigned, certify that I am the legal guardian of __________________________ [child’s name] and that all information provided in this document is true to the best of my knowledge.

_________________________ Parent/Guardian Signature

_________________________ Date

Relationship to Camper: ____________________________

Please return to: Providence Hospice
Attn: Camp Erin Coordinator
2811 South 102nd St, Suite 220
Tukwila, WA 98168-1870

Email: Nicole.sotkiewicz@providence.org
Phone: (206) 749-7689
Fax: (206) 749-7696

Providence Hospice of Seattle complies with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975 as amended, and Section 504 of the Rehabilitation Act. Providence Hospice of Seattle does not discriminate with regard to race, color, religion, creed, national origin, age, sex, marital status or the presence of any sensory, mental or physical handicap, or ability to pay.
CAMP ERIN CAMPER HEALTH FORM

Camp staff, including the camp nurse, may call to follow up. Our nurse will review this form with you at camp check-in.

Camper name: ____________________________________________________________

Gender: ___________________ Date of Birth: ___________________ Age: ___________

Child’s physician name: _______________________________ Phone: ____________________

Does the child have any of the following: Please describe:

- History of serious or chronic illness
  - Yes  □ No  □

- Hearing impairment
  - Yes  □ No  □

- Visual Impairment
  - Yes  □ No  □

- Dietary Restrictions
  - Yes  □ No  □

- Allergies (food, medicine, and/or other)
  □ Yes  □ No

Please describe in detail any allergies (food, medicine, plant, animal/insect and/or other) the child has. Please note severity of allergy and describe allergic reaction. If medication is required, please list type, frequency and dosage.

________________________________________________________________________

________________________________________________________________________

Medications: List medications and specify what the medication is used for, when it should be taken, and what the dosage is. **ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINER WITH THE CAMPER’S PRESCRIPTION.**

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Used for</th>
<th>To be taken at</th>
<th>Dosage</th>
<th>Other information</th>
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6. Treatment/interventions at camp

- May the camper receive Tylenol for pain or fever as needed? □ Yes □ No
- May the camper receive Benadryl for allergies as needed? □ Yes □ No
- May the camper use sunscreen as needed? □ Yes □ No
- May the camper use insect repellent as needed? □ Yes □ No
- May the camper receive cough drops as needed? □ Yes □ No
Child’s Name: ______________________________

7. **Medical considerations/restrictions**: Our goal at Camp Erin is to accommodate the different needs of our campers and to learn how we might best support those needs. Does the child experience any of the following:

- Language Needs
- Physical limitations/differently abled
- Difficulty interacting with children/adults
- Sensitivity to external stimuli

Has the child had any type of behavioral health diagnosis (e.g., mental health condition, ADD/ADHD, etc.)? □ Yes □ No

If yes, please describe: _________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Is there any other specific information/needs/restrictions that we should know about the camper?
_____________________________________________________________________________________
_____________________________________________________________________________________

**PARENT/GUARDIAN SIGNATURES**

**Parent/guardian**: I verify that the above medical information is complete and accurate and that my child has no medical conditions or diagnoses that would prohibit him/her from safely participating in camp. I hereby authorize the calling of a physician to provide whatever emergency medical or surgical treatment is necessary including: X-rays, routine tests, hospitalization, anesthesia and/or surgery for the camper as named above in the event I cannot be reached in an emergency. This form may be photocopied for use out of camp.

Parent/guardian signature: ___________________________________________________________

Parent/guardian name (print): ___________________________________ Date: ______________

**DON’T SIGN THIS NOW.** Sign this at check-in after you have reviewed the medication needs of your child.

**Drop Off**

**Parent/Guardian**: I hereby authorize the nurse to give _____________________ the medications(s) listed and described above.

Parent/ Guardian signature: ___________________________________________________________

Parent Name printed: __________________________ Date: ______________

**Pick up**

I have received the medication listed above back that was dropped off at the start of camp.

Parent/ Guardian signature: _________________________________________________________

Parent Name printed: __________________________ Date: ______________