Hospice of Ohio County's

DAY OF HOPE

A free program for youth ages 6 - 18

Date: Wednesday, May 25th

Time: 10 AM to 2 PM

Location: Ohio County Park

2300 KY Route 69, Hartford, KY 42347

List of Activities

- Equine Assisted Therapy (EAP)
- Student Outdoor Experience Activities
- Crafts
- Grief Education
- Service of Remembrance

Who Should Attend?

Youth ages 6 - 18 who could benefit from grief education and emotional support.

Purpose of the Camp?

The goals of Day of Hope are to offer an opportunity for young people to commemorate and remember loved ones, and to better understand the emotions associated with loss and grief.

To Register or for more information, contact:

Hospice of Ohio County
Phone: 270-298-9507
or Phone: 270-256-6099
email: lshaffer@ochcares.com

For Downloadable Application visit:
www.ochcares.com/hospice

The Cost is FREE.

Please Return Registration Packet by May 4th, or call to register your child after this date.

Participant Application Form

Hospice of OHIO COUNTY

Wednesday, May 25th
10 AM - 2 PM

Ohio County Park

2300 KY Route 69
Hartford, KY 42347

AGES 6 TO 18

Participant: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

School: _____ Grade in School: _____

Parent/Guardian: _____

Phone Numbers: Home _____ Other _____ Emergency _____

Is there any additional medical or other information that we should know about your child?

_____

_____

Are there any other concerns regarding your child of which you want us to be aware?

_____

_____

Name of Deceased Loved One: _____ Date of Death: _____

Relationship to Child: (Parent, Grandparent, Sibling, Friend, etc.) _____

What did your child call Loved One? _____

Please note any helpful information regarding the loved one's illness/death:

_____

_____

_____

Since the death, has your child shown any of the following behaviors? (Check ALL that apply):

____ Problems in school	____ Problems with appetite	____ Lack of interest in usual activities
____ Withdrawing from family/friends	____ Problems with sleeping	____ Demands more attention
____ Seems angry a lot	____ Nightmares	____ Other Behaviors?
	____ Lack of energy	_____
		_____

Reminder: Please send a photo of your loved one and have child wear tennis shoes.
NO FLIP FLOPS PLEASE

Participant Health History Form

CHILD'S NAME: _____ _____ _____
First Middle Last

☐ **MALE** ☐ **FEMALE** **AGE:** _____ **DATE OF BIRTH:** _____/_____/_____

ADDRESS: _____

_____

MOTHER'S / GUARDIAN'S NAME: _____

PHONE NUMBERS: Home: _____ Other: _____ Emergency: _____

FATHER'S / GUARDIAN'S NAME: _____

PHONE NUMBERS: Home: _____ Other: _____ Emergency: _____

CONTACT INFORMATION IN CASE OF EMERGENCY AND PARENTS/GUARDIAN UNAVAILABLE:

FIRST CONTACT'S NAME: _____

PHONE NUMBERS: Home: _____ Other: _____

SECOND CONTACT'S NAME: _____

PHONE NUMBERS: Home: _____ Other: _____

Child's Health History (check ALL that apply)

_____ DIABETES
_____ HEART DISEASE
_____ KIDNEY DISEASE
_____ ASTHMA
_____ EPILEPSY
_____ FAINTING
_____ CONVULSIONS/SEIZURES
_____ OTHER (Please List):
_____
_____
_____

_____ EMOTIONAL PROBLEMS
_____ EAR INFECTIONS
_____ HEARING IMPAIRMENT
_____ NOSE BLEEDS
_____ WEARS GLASSES
_____ WEARS CONTACT LENSES
_____ SPECIAL DIET NEEDS (List):
_____
_____
_____

_____ ALLERGIC TO BEE STINGS/ INSECT BITES?
_____ CHILD REQUIRES/CARRIES AN EPIPEN?

PLEASE LIST ALLERGIES:

___ ANIMALS:
_____
___ FOOD:
_____
___ GRASSES / TREES:
_____
___ MEDICATIONS / OTHER:
_____

Participant Health History Form continued...

Regarding any "checked" health conditions, please indicate any additional information that would be useful to the Camp Directors: _____

_____

_____

Are there other medical issues the Camp Directors should be aware of that are not listed? Please be specific:

_____

_____

_____

Please indicate any activities to be discouraged or restricted for your child:

_____

MEDICATIONS:

Please list all current medications prescribed for your child that will need to be administered while at Day of Hope, along with the purpose and dosage of each:

	NAME OF MEDICATION	PURPOSE	AMOUNT TO BE GIVEN
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Please list the date of the child's last Tetanus injection: _____

I hereby give permission to the Program Nurse to administer prescriptions and over-the-counter medications brought from home, to administer First-Aid to my child if needed, and/or to access medical treatment for my child if needed.

_____ _____

Signature of Parent/Guardian Date

PHOTO AND STORY RELEASE AUTHORIZATION

Regarding my/ my child's participation in Day of Hope, I hereby grant Hospice of Ohio County permission to use any photos / videos that may be taken of me / my child, or in which I / my child may be included with others. I also grant permission for the use of my / my child's name and / or quotations of my / my child's remarks, in whole or in part, for public information and promotion purposes.

I understand that the photographic images and written information may be used for the purpose of promoting Hospice of Ohio County. Promotions may be in the form of all media, print and / or broadcast, website content, or public presentations.

_____ _____

My Name (Please Print) **My Child's Name** (Please Print)

_____ **Relationship to Child:** ☐ Parent ☐ Guardian

My Signature

My Address: _____

_____

Phone Number: _____ Other Phone Number: _____

_____

Witness Signature:

_____

Organization: