



Hospice of Ohio County's **DAY OF HOPE**

A free program for youth ages 6 - 18

Date: Wednesday, June 4th

Time: 10 AM to 3 PM

Check In: 9:15 - 9:45 AM

Location: Ohio County Park

Building #1 (At the top of the hill)

2300 KY Route 69, Hartford, KY 42347

Camp Activities

- Grief & Emotion Education
- Outdoor Experiences
- Guided Horse Riding (Equine Therapy)
- Remembrance Activities & Crafts

Purpose of the Camp

Day of Hope offers an opportunity for young people to commemorate and remember loved ones, and to better understand the emotions associated with loss and grief in a supportive and fun setting.

Who Should Attend?

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

To Register or for more information, contact:

For Downloadable Application visit:

www.ochcares.com/hospice

Hospice of Ohio County

Office: 270-298-9507

Personal: 270-256-6099

email: lschaffer@ochcares.com



The Cost is FREE.

Please call to register your child ASAP, (space is limited) and return registration packet by May 16th to secure a spot. After this date, please call (270) 298- 9507 as youth will be accepted on an individual basis.



Participant Application Form



Wednesday, June 4th
10 AM - 3 PM
Check In: 9:15 AM - 9:45 AM
 Ohio County Park
 Building #1
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: _____ Email _____

Bereavement History

Please list child's most impactful or recent loss first, then others that may affect their grief experience.

NAME	Relationship And what child called them	Date of Death	Age of Death	Cause of Death Or any other info you'd like to share

Please note any helpful information regarding your child's current grief response:

Since their death(s), 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 | |

Participant Health History Form

CHILD'S
NAME:

First

Middle

Last

☐ MALE

☐ FEMALE

AGE: _____

DATE OF BIRTH: ____/____/____

ADDRESS:

Parent / Guardian # 1 Name and Relationship: _____

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

Parent / Guardian # 2 Name and Relationship: _____

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 Day of Hope nursing staff 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, including transportation, if I can not be reached in an emergency.

Signature of Parent/Guardian

Date

Hospice of Ohio County
DAY OF HOPE INFORMED CONSENT, AGREEMENT,
RELEASE OF LIABILITY AND PHOTO PERMISSION/RELEASE

Informed Consent

I hereby give permission for my child, _____ to attend Day of Hope on May 23, 2023 and I understand that Day of Hope's goal is to help facilitate the bereavement process of my child and provide support for him/her in expressing feelings of grief.

_____ **Parent/Guardian Initials**

Waiver and Release of Liability

As parent or guardian of my child, I agree that I will not hold Day of Hope, (a program of Hospice of Ohio County), its employees, officers, directors, volunteers, agents and contractors liable for any personal injury, property damage, loss of insurance. I agree to release and hold harmless Hospice of Ohio County, its employees, officers, directors, volunteers, agents and contractors from all liability incurred as a result of my child's participation in camp, and that these terms serve as a release for myself and members of my family.

_____ **Parent/Guardian Initials**

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.

Parent / Guardian Name (please print)

Parent / Guardian Signature

Date

OHIO COUNTY EQUESTRIAN, INC.

LIABILITY RELEASE FORM

By signing this agreement, I understand that I release and forever discharge Ohio County Equestrian, Inc., John and Rhonda Leach, their heirs, volunteers, livestock, and anyone involved with the corporation from any and all liability or responsibility for injury, loss, or damage the person named below may suffer, from any cause whatsoever, whether such injury, loss, or damage may be occasioned by the negligence of Ohio County Equestrian, Inc., John and Rhonda Leach, their heirs, volunteers, or anyone involved with said corporation.

Rider's printed name _____

Rider's signature (if over age 18) _____ Date _____

Parent/Guardian printed name _____

Parent/Guardian signature _____ Date _____

Riders over age 18 must sign their own name. An "X" must be witnessed by someone over 18 years of age and sign below.

Witness printed name _____

Witness _____ Date _____

MEDIA RELEASE CLAUSE**

I give my permission for Ohio County Equestrian, Inc. to use my likeness, name, and/or voice on television, radio, pictures, etc., to promote this program by any of the above media as deemed appropriate by Ohio County Equestrian, Inc.

Authorized printed name _____

Authorized Signature _____ Date _____

** You do not have to sign the media release to ride, but we would truly appreciate it if you would.