



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

*A free program for youth ages 6 - 18*

**Date:** Thursday, June 5th

**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](http://www.ochcares.com/hospice)



Hospice of Ohio County

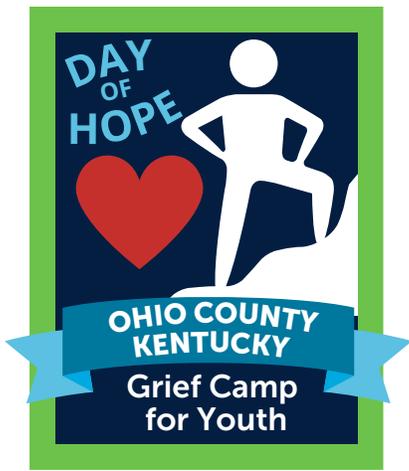
Office: 270-298-9507

Personal: 270-256-6099

email: [lshaffer@ochcares.com](mailto:lshaffer@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

**Thursday, June 5th**  
**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)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Problems in school              | <input type="checkbox"/> Problems with appetite | <input type="checkbox"/> Lack of interest in usual activities |
| <input type="checkbox"/> Withdrawing from family/friends | <input type="checkbox"/> Problems with sleeping | <input type="checkbox"/> Demands more attention               |
| <input type="checkbox"/> Seems angry a lot               | <input type="checkbox"/> Nightmares             | <input type="checkbox"/> Other Behaviors?                     |
|  | <input type="checkbox"/> 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**

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**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**

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**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.

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**Parent / Guardian Name (please print)**

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**Parent / Guardian Signature**

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**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.