



## BRIDGES OF HOPE . . .

a HODC day camp for children who are grieving

**SATURDAY, SEPTEMBER 25, 2010**

**9:00 am — 2:00 pm**

For more information call  
1.336.475.5444

### Grief Camp

uniquely designed to meet the needs of 1st—8th grade children

*HODC's mission is to provide a safe, compassionate environment where grieving children can have fun while learning valuable coping skills in dealing with the death of a loved one.*

*Through a combination of therapeutic and fun activities, children can express their feelings while interacting and gaining support from peers who are experiencing a similar loss. Skilled HODC staff, along with carefully trained volunteers, will offer a day of arts and crafts, music therapy, pet therapy, and creative play.*

*A class for adults will be offered at 12:30 pm to assist in exploring personal grief and identify ways to best support grieving children who share their loss. Adults are encouraged to join camp participants in a closing ceremony at 1:30 pm.*

# BRIDGES OF HOPE YOUTH GRIEF CAMP REGISTRATION FORM

(Please use a separate form for each camper)

Camper Name: \_\_\_\_\_ Likes to be called: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Current Grade: \_\_\_\_\_ Gender: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Physical Address: \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Mailing Address (if different than above): \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

## CONTACT INFORMATION:

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of person who died & relationship to camper: \_\_\_\_\_

What did the camper call this person? \_\_\_\_\_

Date of death? \_\_\_\_\_ Cause of death? \_\_\_\_\_

Is the camper aware of the cause of death?  Yes  No If no, what was the camper told?  
\_\_\_\_\_

Was this person a patient of Hospice of Davidson County?  Yes  No

List other losses, behaviors or current stressors that you feel would be helpful for us to know about:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has camper previously attended a grief camp?  Yes  No If so, when?  
\_\_\_\_\_

Has camper received counseling related to the loss?  Yes  No

My child has my permission to participate in supervised outdoor recreational activities and I grant permission for photographs/videos, written evaluation comments, or interviews with me or my child to be used for educational purposes and/or to promote future camps.  Yes  No

How did you hear about Bridges of Hope? \_\_\_\_\_

Signature (Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

**A \$10.00 DEPOSIT IS DUE WITH EACH REGISTRATION FORM. THERE IS NO ADDITIONAL COST. NO CHILD WILL BE TURNED AWAY DUE TO INABILITY TO PAY. PLEASE CONTACT HODC FOR SCHOLARSHIP AVAILABILITY. TO HELP ENSURE SPACE, SUBMIT APPLICATION BY SEPTEMBER 17TH. CONTACT HODC FOR MORE INFORMATION 1.336.475.5444. UPON RECEIPT OF DEPOSIT, WE WILL CONTACT YOU WITH ADDITIONAL CAMP INFORMATION.**

# MEDICAL & OTHER IMPORTANT INFORMATION

Camper Name: \_\_\_\_\_  
(Please Print)

Are there any activities that should be restricted? \_\_\_\_\_  
\_\_\_\_\_

Lunch and snack will be provided for the camper. Are there any special dietary needs? \_\_\_\_\_  
\_\_\_\_\_

Please list any allergies \_\_\_\_\_

Please administer medication and/or bring allergy medications to camp with you. (Medications must be labeled with the camper's name.)

Parents be sure to bring any special items your child may need (sunscreen, change of clothes, etc...) Dress for comfort. **Closed-toe shoes are required.**

Parent/Guardian must accompany camper to registration/camp check-in. Please contact HODC if you have transportation needs.

Camper T-Shirt Size:    Youth Small    Youth Medium    Youth Large    Youth XL

## IN CASE OF EMERGENCY NOTIFY:

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

## PHYSICIAN INFORMATION

Primary Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## AUTHORIZATION

In case of emergency, I give permission to HODC staff to provide first aid, medical care, and to transport me/ my child to the nearest medical facility. I agree to be financially responsible for any care received by my child or myself.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Additional Information: \_\_\_\_\_  
\_\_\_\_\_



200 HOSPICE WAY  
LEXINGTON, NC 27292  
1.336.475.5444



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*This camp was made possible through the generous support of the Lexington Jaycees. Their mission is to provide development opportunities that empower young people to create positive change. Their hope is that youth participating in the Bridges of Hope day camp will be better equipped to process their grief and resume activities wholeheartedly. For more information regarding the Lexington Jaycees call: 336.224.0751 or email: [lexingtonjaycee@yahoo.com](mailto:lexingtonjaycee@yahoo.com).*