WEST GEORGIA HOSPICE
CAMP DOGWOOD APPLICATION

Please complete and return to West Georgia Hospice / Camp Dogwood
via email (Sandra.Melton@Wellstar.org) or fax (706-812-2650).
If you have questions, please call Sandra Melton at 706-845-3962.

Space is limited and applications are reviewed in the order they are received.
It is important that this application is completed in its entirety.

Today's date:			Person completing form:		
CAMPER INFORMATION					
Child's last name: First:			Middle:	Preferred Name:	T-Shirt Size:
Birth date: / /	Age: ❑ M ❑ F	Sex:	Street address:		
Name of School:		Grade:	City:	State:	ZIP Code:
Name of Parent(s)/Guardian(s):			Phone:	Alternate Phone:	Email:
Relationship to Child:			Address (if different from above)		
Alternate Emergency Contact (Name and relation):			Contact Numbers:		

CONSENT AND AUTHORIZATION

TO PHOTOGRAPH/PUBLISH:
(I)(We), the undersigned, parent(s) of _____ (print child's name), a minor, do consent on his/her behalf to allow the agents of Camp Dogwood to photograph (still and/or motion) my child and I understand that these photos may be used in the promotion and publicity of Camp Dogwood.

_____ _____
Parent/Guardian Signature *Date:*

FOR MEDICAL CARE/MEDICATION ADMINISTRATION:
(I)(We), the undersigned, parent(s) of _____ (print child's name), a minor, do consent on his/her behalf to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care deemed advisable by, and is to be rendered under the general or specific supervision of, any physician and surgeon licensed by the State Board of Medical Examiners on the medical staff at West Georgia Health in LaGrange, Georgia whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis or hospital care being required, but is given to provide specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable in the event of an emergency. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. We also authorize and request that Camp Dogwood to administer the medication(s) (if any) prescribed by our physician, and in doing so relieve the Camp, it's agents, employees or representatives, of any responsibility for ill effects which may result from the administering of said prescription medication as per the physician's directions printed on the medication label. This authorization shall remain in effect while this child is in attendance at camp, at Camp Dogwood, LaGrange, Georgia.

_____ _____
Parent/Guardian Signature *Date:*

FOR PARTICIPATION IN CAMP DOGWOOD:
(I)(We), the undersigned, parent(s) of _____ (print child's name), a minor, do consent on his/her behalf to participate in a retreat sponsored by West Georgia Hospice/Camp Dogwood. I recognize and acknowledge that there are outdoor, camp, and water activities at Camp Dogwood which involve risks of serious physical injuries to my child. I FULLY ACCEPT THE RISKS INVOLVED IN THESE ACTIVITIES AND I FULLY AND COMPLETELY RELEASE WEST GEORGIA HOSPICE/CAMP DOGWOOD, AND IT'S AGENTS AND REPRESENTATIVES, ALL AFFILIATED ORGANIZATIONS, THEIR DIRECTORS, OFFICERS, STAFF, AND EMPLOYEES FROM ANY LIABILITY OR CLAIM FOR DAMAGES OF ANY KIND ARISING FROM MY CHILD'S PARTICIPATION IN THESE ACTIVITIES. Any special needs, including medical concerns for my child have been made known to the staff at Camp Dogwood in this application. In addition, I have made Camp Dogwood aware of any known allergies that my child has and have specified in writing to Camp Dogwood of any restricted activities while at Camp Dogwood. I, therefore, understand and release Camp Dogwood, and its agents and Representatives from any liability for my child during the time of the retreat at Camp Dogwood.

_____ _____
Parent/Guardian Signature *Date*

PLEASE PRINT CHILD'S NAME:_____ Sex:____ Age:____

BEREAVEMENT FORM

Please include as many details as possible when answering the following questions.

Name of Person who died:	How was this person related to the child?	Date of Death:
Describe the circumstances of the death – **how, when, where**		Was child present at death?
Describe in detail this child's relationship with the deceased and in detail how his/her life has been affected by the death. What does the death mean to your child?		
Did the child have a special name for the person who died? If so what was that name?		
Have you noticed any significant behavioral changes in the child after the death of their loved one? If yes please describe the changes.		
Does the child a history or mental illness or a developmental disability?		
Has the child had a history of depression or thoughts of suicide?		
Does the child have a history as a victim of abuse?		

PLEASE PRINT CHILD'S NAME:_____ Sex:____ Age:____

MEDICAL FORM

Emergency Contact:	**Alternate Contact:**
Child's Physician:	**Physician's Phone Number:**

ALLERGIES

Please list allergies to medication, food, and others including insect stings, animal dander, etc.

Allergic to:	What happens?	What is done to help with reaction?

MEDICAL HISTORY

Please check all that apply.

❑ Heart Condition	❑ Frequent Colds	❑ Diabetes	❑ Asthma	❑ Physical Handicap
❑ Epilepsy/Seizures	❑ Stomach Upsets	❑ Chronic Bronchitis	❑ Emotional Difficulties	❑ Skin problems
❑ ADD / ADHD *(circle)*	❑ HIV / AIDS	❑ Constipation/Diarrhea	❑ Hearing Impairment	❑ Vision Impairment
❑ Bed-wetting	❑ Physical Handicap	❑ Autism/Asperger's	❑ Mental Health Diagnosis	❑ Other

Please explain any checked boxed above:

MEDICATIONS

Please list all medications (including over the counter medications) your child is currently taking.

❑ My child does not currently take any medications **❑ My child takes the medications listed below**

Medication:	Taken for:	Dosage:	Time(s) taken each day:

INSURANCE

Is this child covered by medical insurance? ❑ Yes ❑ No	If so, please list carrier/plan name:
Insurance group/ID number:	Subscriber's name:

OTHER INFORMATION

Please list any other pertinent medical information regarding your child:

SUBMIT Email form to **sandra.melton@wellstar.org**.
Please save and attach your form to the email. Thanks!