

CAMP **HEART SONGS**

➔ Walking the journey of grief together ➔

2022 Camper Registration Packet

**Four Seasons
571 South Allen Road
Flat Rock, NC 28731
(828) 692.6178**

Email: compass@fourseasonscfl.org

Website: www.fourseasonscfl.org

Need to Know:

**Where: YMCA Youth Services at Beaverdam
201 Beaverdam Road
Asheville, NC 28804**

Who: Those 5-15 years of age

When: Saturday, August 27, 2022

10:00AM-7:00PM

Camp Registration is from 9:30AM to 10:00AM.

Camp will begin promptly at 10:00AM.

THIS PACKET MUST BE RETURNED BY FRIDAY, AUGUST 12, 2022



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Camp Heart Songs Registration Form

1. Child

First Name: _____ Last Name: _____

Preferred Name: _____ Gender: _____ Male _____ Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: ____ / ____ / ____ Age: _____

School Name: _____ Grade (2022-2023): _____

Child's T-Shirt Size: _____ (Please indicate child or adult sizing.)

2. Parent / Legal Guardian #1:

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Contact Number: _____

Email Address: _____

3. Parent / Legal Guardian #2:

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Contact Number: _____

Email Address: _____

4. Emergency Contact (if parents / legal guardians listed above are unavailable)

First Name: _____ Last Name: _____

Relationship to Child: _____

Primary Contact Number: _____

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Information About the Death / Loss

Child's Name: _____

Name of the person who has died / is ill: _____

Relationship to the person who has died / is ill: _____

Date of death / onset of illness: _____ Age of Deceased / Loved One: _____

Was / Is this person a patient at Four Seasons? Yes No

Place of death / care: Home Hospital Other: _____

Nature of death / illness: Illness Accident Homicide
 Suicide Other: _____

Is this your child's first experience with death / terminal illness?
 Yes No

Did your child attend a memorial for this person?
 Yes No Not Applicable

Has your child received a physical/medical exam since the loved one's death / onset of illness?
 Yes No

Has your child received any professional support since the death / onset of illness?
 Yes No

If yes, please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Grief Support Counseling | <input type="checkbox"/> School Counselor |
| <input type="checkbox"/> Minister, Priest, Rabbi, etc. | <input type="checkbox"/> Other Counselor |
| <input type="checkbox"/> Family Physician | <input type="checkbox"/> Other: _____ |

How would you describe the child's relationship with the person who has died / is ill?

History of Losses:

Relationship To Child	Cause of Death	Date of Death

Note other recent losses, changes, or stressors in your child's life (i.e., divorce, incarceration, finances):

Which of the following activities have been helpful to your child during their grief journey?

- Talking with a friend
- Talking with family
- Writing or drawing
- Physical activity/sports
- Visiting the grave
- Talking with a supportive person (minister, teacher, etc.)
- Other: _____

Has your child ever experienced abuse or neglect of any kind?

Yes No

Has your child or another member of your family experienced emotional or mental health issues for which they have received professional support?

Yes No

If yes, please explain: _____

Is there anything else you would like us to know about your child? _____

This grief history is correct to the best of my knowledge.

Parent/ Legal Guardian Signature: _____

Date: _____

The information I have provided is confidential and will only be used by the staff and volunteers present at the camp for the purpose of supporting my child in the best way possible.

Parent / Legal Guardian Initials: _____



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Health History / Medical Information

First Name: _____ Last Name: _____

Gender: ___ Male ___ Female Height: _____ Weight: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: ___ / ___ / ___ Age: _____

Health History (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Motion sickness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Wears contact lenses |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Wears glasses |
| <input type="checkbox"/> Nose bleeds | |
| <input type="checkbox"/> Other: _____ | |

Please explain any “checked” answers from the previous question. Indicate any information important to know in relation to any of your child’s health history / health conditions.

I understand that I will be notified in the case of a medical emergency involving my child. If I cannot be reached, I authorize the calling of a doctor and providing of necessary medical services in the event my child is injured or becomes ill.

Parent / Legal Guardian Initials: _____

I understand that Four Seasons, its’ owners and its’ employees and volunteers will not be responsible for any medical expenses that may be incurred, but that such expenses will be my responsibility as the parent / legal guardian.

Parent / Legal Guardian Initials: _____

Health Insurance Provider: _____

Policy Number: _____

Primary Physician: _____

Address: _____

Phone Number: _____

Preferred Hospital: _____

Please list current medications prescribed for your child and the purpose of each.

Name of Medication

Purpose and Directions for use

1. _____

2. _____

3. _____

4. _____

5. _____

Is your child presently being treated for an injury or sickness, or taking any form of medication for any reason?

Does your child have food, medication, or environmental allergies?

Does your child require a special diet?

Are there any restrictions or limitations for your child on camp activities?

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or after treatment. Is there any additional medical information that we need to be aware of for your child?

I give permission to the Four Seasons/Camp Heart Songs nurse to administer prescriptions, over the counter medications brought from home, first aid and/or access to medical treatment if needed for my child.

Parent / Legal Guardian Initials: _____



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Request for Medication Administration

*****Fill out only if your child needs to receive medication*****

Camper's Name: _____

I request that my child receive medication during camp hours. I release Four Seasons and its agents and employees from all liability that may result from my child taking the prescribed medication.

This medication will be furnished by parent or legal guardian in original container labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, and expiration date).

Parent / Legal Guardian's Signature: _____ Date: _____

Medication: _____ **Dosage:** _____

Time(s) medication is to be given: _____ A.M. _____ P.M.

Significant Information: (side effects, toxic reactions, and omission reactions):

If an emergency occurs during the camp day, or if the camper becomes ill, camp staff should:

- a. Contact Physician
 - a. Name: _____
 - b. Phone: _____
- b. Take child immediately to the emergency room
 - a. Preferred Hospital: _____
- c. Other: _____

Camp Use Only:

Name and title of person to administer medication: _____

Approved by: _____ Date: _____
RN Signature

Medication administered: Time: _____ Dosage: _____

Administered by: _____ Date: _____

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ACKNOWLEDGEMENT OF RISK AND ASSUMPTION OF PERSONAL RESPONSIBILITY

I understand that during my participation in all activities at YMCA Youth Services at Beaverdam during **Camp Heart Songs** on August 27, 2022, we will be exposed to risks.

I also understand that although YMCA Youth Services at Beaverdam has taken precautions to provide proper equipment and specific instructions for the activities used, it is impossible to guarantee absolute safety. I understand that we share the responsibility for safety at the camp and in the activities and we assume that responsibility.

I have accepted responsibility to verify with my physician that we have no physical or psychological problems that would prohibit our participation in the program. I agree to comply with the instructions, directions, and rules of the YMCA Youth Services at Beaverdam and staff members during the program.

Print Name of Child: _____

Print Name of Parent / Legal Guardian: _____

Signature of Parent / Legal Guardian: _____

Date: _____



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Permission to Pick Up Form

The following people have permission to pick up my child if I cannot do so. I understand that the person picking up my child will need a picture ID before they will be allowed to leave with my child.

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Print Name of Child: _____

Print Name of Parent / Legal Guardian: _____

Signature of Parent / Legal Guardian: _____

Date: _____

Witness: _____

Date: _____



INFORMED CONSENT AND INDEMNIFICATION AGREEMENT

1. We/I _____, hereby give permission for our/my child, _____ to attend **Camp Heart Songs** on Saturday August 27, 2022.

We/I understand that the camp's goal is to help facilitate the bereavement process of our/my child and provide support for him/her in expressing feelings of grief.

2. In due consideration of the above-named child being granted permission by Four Seasons to attend **Camp Heart Songs**,

WE/I, FOR OURSELVES/MYSELF AND ON BEHALF OF OUR/MY CHILD, RELEASE AND DISCHARGE FOUR SEASONS, ITS OFFICERS, DIRECTORS, ADMINISTRATORS, VOLUNTEERS, EMPLOYEES, AGENTS, SUCCESSORS, AND ASSIGNS, AND ALL OTHER PERSONS WHO ARE ASSOCIATED WITH FOUR SEASONS WHO MIGHT BE CLAIMED TO BE LIABLE FROM ANY AND ALL CLAIMS, DEMANDS, ACTIONS, JUDGMENTS, CAUSES OF ACTION OR SUITS OF ANY KIND OR NATURE WHATSOEVER, EITHER IN LAW OR EQUITY, WHICH WE/I OR OUR/MY CHILD EVER HAD OR NOW HAS OR MAY HAVE AGAINST FOUR SEASONS AND FROM ANY LIABILITY ON ITS PART ARISING FROM OR BY REASON OF ANY MATTERS AND THINGS WHATSOEVER INCLUDING BUT NOT LIMITED TO BODILY INJURY OR PERSONAL INJURIES, PHYSICAL OR EMOTIONAL, KNOWN OR UNKNOWN, SUSTAINED BY OUR/MY CHILD AND/OR THE DAMAGE OR INJURY TO PROPERTY, REAL OR PERSONAL OR OTHERWISE, SUSTAINED BY OUR/MY CHILD'S PROPERTY FROM THE COMMENCEMENT OF THE CHILD BEING ACCEPTED AND GRANTED PERMISSION TO ATTEND **Camp Heart Songs** BY FOUR SEASONS THROUGHOUT HIS/HER ATTENDANCE AT **Camp Heart Songs** UNTIL SAID CHILD IS RETURNED INTO OUR/MY CARE, HOWEVER SAID INJURY OR DAMAGE MAY OCCUR, WHETHER THE CAUSE IS BY NEGLIGENCE OF THE CHILD OR BY FOUR SEASONS OR THROUGH ANY OTHER FAULT.

3. In due consideration of the above-named child being granted permission by Four Seasons to attend **Camp Heart Songs**.

WE/I AGREE, JOINTLY AND SEVERALLY, TO INDEMNIFY AND HOLD FOUR SEASONS HARMLESS AGAINST ANY LIABILITY ON ITS PART FOR ANY CLAIMS,

DEMANDS, ACTIONS, JUDGMENTS, CAUSES OF ACTIONS OR SUITS OF ANY KIND OR NATURE WHATSOEVER, EITHER IN LAW OR EQUITY, ARISING OUT OF ANY MATTERS AND THINGS WHATSOEVER INCLUDING BUT NOT LIMITED TO BODILY INJURY OR PERSONAL INJURIES, PHYSICAL OR EMOTIONAL, KNOWN OR UNKNOWN, SUSTAINED BY OUR/MY CHILD AND/OR THE DAMAGE OR INJURY TO PROPERTY, REAL OR PERSONAL OR OTHERWISE, SUSTAINED BY OUR/MY CHILD'S PROPERTY FROM THE COMMENCEMENT OF THE CHILD BEING ACCEPTED AND GRANTED PERMISSION TO ATTEND **Camp Heart Songs** BY FOUR SEASONS THROUGHOUT HIS/HER ATTENDANCE AT **Camp Heart Songs** UNTIL SAID CHILD IS RETURNED INTO OUR/MY CARE, HOWEVER SAID INJURY OR DAMAGE MAY OCCUR, WETHER THE CAUSE IS BY NEGLIGENCE OF THE CHILD OR BY FOUR SEASONS OR THROUGH ANY OTHER FAULT.

4. The purpose of this Agreement is to obtain from the child's parent(s)/guardian(s) a release, discharge and indemnification for all matters delineated above.
5. This Agreement shall be binding on and shall insure to the benefit of the parties and their respective legal representatives, employees, agents, successors, heirs and assigns.
6. The consideration for this Agreement is the acceptance of the child into the program sponsored by Four Seasons called **Camp Heart Songs**.
7. This Agreement shall be governed by and construed in accordance with the laws of the state of North Carolina.

_____	_____
Parent/ Legal Guardian Signature	Date
_____	_____
Witness Signature	Date

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What to bring to camp:

- A great attitude
- Sunscreen
- Any medication needed during camp hours
- Bug spray
- Sunglasses or hat

What to leave at home:

- Cell phones
- Handheld games
- Anything that will distract you from fun at camp

What to wear:

- Comfortable clothes, shorts and T-shirts work well
- **Socks and lace up tennis shoes/closed toed shoes** – you **cannot** attend camp without these – YMCA rules!!



**Directions to YMCA Beaverdam
201 Beaverdam Road
Asheville, NC 28804**

From Asheville:

Take I-240 towards Asheville. Take Exit 5A to Merrimon Ave. In 2.27 miles turn right onto Beaverdam Rd (next to Ingles). Beaverdam YMCA campus will be on your right (half a mile).

From Hendersonville/Fletcher:

Travel I-26 West to Asheville. Merge onto I-240 towards Asheville. Take Exit 5A to Merrimon Ave. In 2.27 miles turn right onto Beaverdam Rd (next to Ingles). Beaverdam YMCA campus will be on your right (half a mile).

From Waynesville:

Travel I-40 East to Asheville. Merge onto I-240 towards Asheville. Take Exit 5A to Merrimon Ave. In 2.27 miles turn right onto Beaverdam Rd (next to Ingles). Beaverdam YMCA campus will be on your right (half a mile).



The Care You Trust

PATIENT/CLIENT PHOTO AND VIDEO CONSENT FORM

Patient Name: _____ Birth Date: ____/____/____

Address: _____

Phone Number: _____ Email: _____

I understand that I am under no obligation to sign this form and that Four Seasons, the organization described below who I am authorizing to use and/or disclose my health information, may not condition treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

1. I authorize Four Seasons to obtain my photo, or include me in a video, and to use my photo or video to promote their organization or the services they offer through various methods – social media, newspapers, etc.
2. I authorize my child’s photo/video to be used and/or disclosed for the following Purpose(s). Please circle one or more and leave comments below when/if necessary:

Marketing, Public Relations, Education, Awareness, Research

3. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact Four Seasons at 828.692.6178.
4. I understand that my photo/image/video may be used on social media platforms, and will therefore be in the public domain, and will not be protected by federal privacy standards.
5. I understand that no one will receive any form of remuneration in connection with the use and/or disclosure of my health information.
6. This authorization will be effective until the following date or event: _____

Patient/Client Signature

Date

If Patient/Client is unable to sign, complete the following:

Reason Unable to Sign

Representative Signature & Relationship

Date