Camp Firefly 2022

Saturday, August 27 at YMCA of the Pines, Medford, NJ

Moorestown Visiting Nurse Association/The Hospice of Moorestown VNA
300 Harper Drive, Moorestown, NJ 08057
(856) 552-1300 ~ www.moorestownvna.org ~ services@moorestownvna.org

Please Print Clearly.

Child's Full Name: _____.

►Review/update the information you previously completed on the attached Inquiry Form. Verify that information is correct.

I have reviewed the Inquiry Form: Signature_____

This application is available to any child who has lost a loved one without regard to race, color, sex, religion, sexual orientation, national origin, or other legally protected classification. Campers must be seven to fourteen years old at the time of camp. Applications are subject to the approval of the Camp Firefly Directors.

SPECIAL REQUIREMENTS DUE TO COVID-19 Please read and initial here INITIAL _____

- All child/guardians will be asked to complete temperature checks and a COVID health questionnaire on arrival.
- Due to the physical nature of some outdoor activities there will be times when children will not be required to wear a mask. During indoor activities MVNA will require all camp attendees to wear mask unless a written notification has been received prior to camp, explaining why it is not possible for the child to wear a mask. MVNA has made arrangements for all meals to be held outside weather permitting to limit indoor contact while eating.
- For the safety of our staff, volunteers and campers, Moorestown VNA complies with up-to-date CDC guidelines regarding COVID-19, but cannot be held accountable for any exposures during camp. Should any camper become positive for COVID-19 in the 10 days following August 27, notify Moorestown VNA so that anyone with potential exposure during camp can be contacted.

Please Note: The PHYSICAN FORM on pages 10/11 will need to be completed by your Child's Primary Medical Provider. Vaccination Records must be provided.

Has the child been vaccinated for COVID? ☐ **YES** (please complete applicable dates) ☐ **NO**
Date of Vaccination #1_____ **Date of Vaccination #2**_____
Date of Vaccination (Booster) #3 _____

Please identify siblings who reside in the child's home:

NAME	AGE

Additional Bereavement Information

It is important for the staff of Camp Firefly to understand as much as possible about your child's experience with death and grief. You can help us meet your child's needs by providing answers to the following questions.

Name of person who died: _____

Cause of death: _____ **Date of death**: _____

Place of death (i.e.; home, hospital, etc.)**:**_____

Childs Name: _____

Please give a brief account of the death (i.e.; length of illness, type of accident, etc.)_____

_____

_____

_____

	YES	NO
Was your child present at the death?	☐	☐
Did your child view the body of the person who died?	☐	☐
Did your child attend the funeral?	☐	☐
Has your child been told the facts about the death?	☐	☐
Does your child understand the facts about the death?	☐	☐

	YES	NO
Has your child received any professional support/counseling?	☐	☐

If yes, please put an "X" next to all that apply:

	Psychologist		Psychiatrist		Counselor
	Hospice bereavement care		School counselor		Minister
	Other (please specify):				

Since the death, has your child shown any of the following behaviors?

Occasional	YES	NO	
Belief that illness/death was his/her fault			
Belief that illness/death is a punishment			
Problems in school			
Withdrawing from family and friends			
Changes in eating/sleeping habits			
Change in weight			
Change in how child feels about him/herself			
Complaints of headaches, stomach aches, backaches, etc.			
Loss of interest in usual activities			
Always trying to act perfect			
Lack of energy			
Wants to die & be with the deceased			
Having more accidents or injuries than usual			
Crying			
Anger			
Depression			
Acting out behavior			
Regression (Ex: thumb sucking, bed wetting, fear of dark, etc)			

	YES	NO
Does your child talk about the death?		

If yes, with whom? _____

Has the camper had suspected or confirmed:	YES	NO
Drug and/or alcohol abuse		
Acting out sexually		
Recent problems with law, shoplifting, vandalism, etc.		
Caring for others, but not caring for self		
Other (Please specify):		

Please comment on any items checked YES:_____

Childs Name: _____

	YES	NO
Does your child have temper tantrums? If yes, please specify below. ☐ yells ☐ throws things ☐ punches/hits ☐ Other:		
Does your child adjust well to new routines?		
Is your child timid with new activities or people?		
Does your child act his/her age? Younger, ☐ His/her age, ☐ Older ☐		

COMMUNICATION/SOCIALIZATION

How does your child interact with peers? (Please put an "X" in front of all that apply)

	Leader		Shy		Follower
	Sensitive		Likes privacy		Needs friend's approval
	Makes friends easily		Argumentative		Competitive
	Interruptive		Other:		Other:

What is your child's response to adult supervision? (Please put an "X" in front of all that apply)

	Cooperative		Competitive		Anger		Belligerent
	Remorseful		Moody		Fearful		Tearful
	Pouting		Manipulative		Non responsive		Other:

What is the best method of gaining your child's cooperation? _____

_____

Have there been any other significant changes for your child in the last 2 years? (i.e., move, baby, new school, divorce, etc)? If so, explain: _____

_____

How many Emergency Room visits has your child had in the past 18 months? 1 2 3 4 5 or more

How many times has your child been hospitalized in the past 2 years? 1 2 3 4 5 or more

Do you have worries or concerns regarding your child's grief?_____

_____

	YES	NO
Can you talk about your own feelings regarding this death with your child?		
Can you talk with your child about the death?		
Is there enough adult support in the home to keep a normal routine for your child?		

Please comment on any of the above items, or add information about your child that might help make camp a successful experience:

_____

_____

_____

_____

_____

_____

_____

Childs Name: _____

PHOTOGRAPH REQUEST

Please include a recent photo of your child with this application

(School photo or other recent close up/head shot)

___ Photo enclosed (Write child's first and last name on the back)

___ I will take a photo with my phone or camera and e-mail it to plasket@moorestownvna.org. Include child's first/and last name.

___ I don't have a recent photo, I will call (856) 552-1300, ext. 2191 to schedule a free photo at "Meet the Counselor Night"

PHOTOGRAPH PERMISSION RELEASE *(Please chose one and Initial)*

INITIAL _____ I give permission for my child to have their photo taken during camp

_____ I do not want my child to have their photo taken at camp

Photo Release Statement: Please refer to page 8

Childs Name: _____ **Date of Birth_____**

MEDICAL INFORMATION – PART 1:

TO BE COMPLETED BY PARENT OR GUARDIAN

ATTACH THE FOLLOWING DOCUMENTS:

1. ____Copy of **Immunization Record**: Must be obtained by Parent/Guardian from Physicians' Office.
2. ____Copy of both sides of the **child's Medical Insurance Card.**

MEDICAL INSURANCE INFORMATION

Insurance Company Name:_____Subscriber:_____

Policy/agreement #: _____ Group #:_____

Primary Physician: _____ Phone # _____

HEALTH HISTORY (CHECK IF YOUR CHILD HAS HAD THE FOLLOWING):

☐	Asthma	☐	Eczema	☐	Heart defect
☐	Bleeding disorder	☐	Fainting spells	☐	Headaches
☐	Sinus infections	☐	Stomach aches	☐	Chicken pox
☐	Measles	☐	German measles	☐	Insect stings
☐	Diabetes	☐	Hay fever	☐	Mumps
☐	Other:	☐	Other:	☐	Other:

_____ Please alert us if child has been exposed to any communicable disease (chicken pox, measles, mumps) 1-3 weeks before camp.

Child's dietary restrictions (if any): _____

_____

Child's activity restrictions (if any): _____

_____

CAMPER'S ALLERGIES

Indicate if the child is allergic to any medications, foods, animal, insects, plants, seasonal allergies, etc:

_____

_____

Does the child require a special diet? _____

Describe:_____

PREVIOUS CAMPING EXPERIENCES

How did you learn about Camp Firefly? (Please put an "X" in front of all that apply)

	School		Friend		Religious institution
	Newspaper		Hospice staff		Radio/TV
	Other, please specify:				

Childs Name: _____

Name and phone # of person who referred you to Camp Firefly: _____

_____

Has a family member ever attended Camp Firefly? ☐ Yes ☐ No If Yes list:

Name of camper _____ Year _____

Name of camper _____ Year _____

Has there been any additional losses since the child the attended Camp Firefly? Who?_____

Has the child previously attended a grief camp ?_____ If yes, name of Camp_____

PARENT/GUARDIAN CERTIFICATION OF ACCURACY OF INFORMATION

I certify that the statements made on this application are true and correct to the best of my knowledge.

DATE: _____ SIGNED: _____

The Hospice of Moorestown VNA

CONSENT FORM - CAMP FIREFLY 2022

Please read carefully - Initial (no x's or check marks!) each paragraph - Sign the document

CAMPER'S NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **ALTERNATE PHONE:** _____

INITIAL I/We, the parent(s) and/or legal guardian(s) of _____, a minor, do hereby authorize the participation of, and accept responsibility for the attendance of, the said minor at The Hospice of Moorestown VNA CAMP FIREFLY program at YMCA of the Pines, 1303 Stokes Rd, Medford, New Jersey, on Saturday to August 27, 2022 and all activities in connection therewith, conducted under the auspices of The HOSPICE of Moorestown VNA and its CAMP FIREFLY program.

INITIAL I/We request that said minor be permitted to participate in said camp, having been fully and completely informed and advised regarding the nature and purpose of said camp and the activities conducted there under. I/We acknowledge that CAMP FIRELY, through its agents and employees, extended every effort to inform, advice, and acquaint each of us with the camp and purpose of participation in these activities by the child so named above. It is my/our full and free decision to allow said child to participate.

INITIAL Furthermore, I/We certify that our child is physically able to participate in camp activities, and hereby authorize the directors of CAMP FIREFLY to act for me/us, according to their best judgment, in any emergency requiring medical attention.

INITIAL I/We hereby grant permission to the nursing staff at the camp to administer routine and other medication for my child, as well as any emergency care as required

INITIAL Neither the YMCA of the Pines, The HOSPICE of Moorestown VNA and/or any affiliated company, nor any individual(s) connected with the CAMP FIREFLY program, assumes any responsibility for accidents; or medical, dental, or any other expenses incurred as a result of accidents while the child was in attendance or participating in the camp. I/We hereby release the YMCA of the Pines, the HOSPICE of Moorestown VNA, and/or any subsidiary, parent, or affiliated entity from any and all liability for any accident or injury suffered by my/our child while in attendance at the Camp and/or while participating in any Camp activities.

INITIAL **I/We certify that someone will be available and accessible all day (August 27, 2022, 8:00 am to 9:00pm) to talk to, or pick up my/our child in the case of an emergency**.

INITIAL I/We also certify that I/We have received and understand all written materials, including the Camp Rules and Camp Information.

*****I UNDERSTAND THAT SOMEONE MUST BE AVAILABLE AND ACCESSIBLE ALL WEEKEND TO TALK TO OR PICK UP MY CHILD IN THE CASE OF AN EMERGENCY.*****

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____**CHILD"S NAME**_____

(RELATIONSHIP TO CHILD)

Childs Name: _____

RELEASE AGREEMENT

(Please read carefully & initial each paragraph & sign the document)

INITIAL
_____Camping and outdoor activities can be strenuous and, by their very nature, contain potential inherent risks. While every attempt has been made to keep the facilities and activities of Camp Firefly at the YMCA of the Pines, located at 1303 Stokes Rd, Medford, New Jersey, as safe and secure as possible, the camp is a large outdoor property subject to natural hazards and to wear and tear by users. It is incumbent upon users of the properties to inform themselves of potential hazards, to dress appropriately, to refrain from unsafe practices, and to report observations of any such potential hazards or unsafe practices to the counselors of the camp.

INITIAL
_____The undersigned agrees, on behalf of the below named child, to accept the risks associated with activities at Camp Firefly by the below-named child. The undersigned shall assume any and all financial responsibility for any injury to the child named below resulting from the child's activities or use of the premises at Camp Firefly.

INITIAL
_____The undersigned for himself/herself and on behalf of the below named child, hereby agrees not to bring an action or claim against The Hospice of Moorestown VNA, its employees, volunteers, and agents if the below named child is hurt or injured while attending Camp Firefly, regardless of any negligence of The Hospice of Moorestown VNA, its employees, volunteers, and agents.

INITIAL
_____This release shall be legally binding upon the undersigned Parent/Guardian, the below named child, their heir(s), executors(s), administrator(s), successor(s), or assign(s).

_____ Date_____
Parent/Guardian Signature

Print Name_____ Print Child's Name_____

Relationship to Child _____

AUTHORIZATION AND ACKNOWLEDGEMENT OF PRIVACY RIGHTS

(Please read carefully & Initial each paragraph & sign the document)

INITIAL
_____I authorize The Hospice of Moorestown Visiting Nurse Association to use and/or disclose the medical information contained within this application to other licensed medical personnel for the purposes of obtaining and facilitating emergency medical treatment for the enrolled child. This authorization shall remain in force and effect throughout the day on August 28, 2021, the time period representing the duration of Camp Firefly.

INITIAL
_____Additionally, I hereby permit and authorize The Hospice of Moorestown Visiting Nurse Association and its employees, agents and representative who are acting in behalf of The Hospice of Moorestown VNA to use the child's enrolled in Camp Firefly there likeness, image, voice and/or name (Collectively referred to as my Likeness"), in any Photograph, image, film or video for any purposes related to its business, the promotion and advertising of its business, or any other lawful purpose, in any media now know or later created with any compensation to me (The Hospice of Moorestown VNA). This authorization shall remain in force and effect until the child's age of 16 years.

Childs Name: _____

___INITIAL___This authorization may be terminated should I furnish written notice of revocation to The Hospice of Moorestown Visiting Nurse Association at the following address:

The Hospice of Moorestown Visiting Nurse Association
300 Harper Drive
Moorestown, NJ 08057

+++IMPORTANT NOTE - THE FOLLOWING AUTHORIZATION WILL BE USED ONLY IN CASE OF EMERGENCY: -

Please read carefully & initial each paragraph & sign the document Unless the authorization is expressly limited, this authorization grants the Covered Entity the right to use or disclose ALL of the personal medical information identified, including information about any diagnosis or treatment for any mental health, substance abuse, sexually transmitted disease (such as HIV), cancer and/or genetic condition, for the purposes described.

___INITIAL___I understand that: (1) a revocation is not effective to the extent that the parties named in this authorization have relied on the use or disclosure of the protected health information prior to the receipt of the revocation; (2) information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law; and (3) my health care provider(s) and health plan(s) may not condition my treatment, payment or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

_____
_____
_____
[Print name and address of individual who is the subject of the information.]

_____ _____
Signature of Individual or Personal Representative Date

If a personal representative is signing the form on behalf of the individual whose medical information is to be used or disclosed, please print the name of the personal representative and describe his or her authority to act on behalf of the individual.

_____
[Name of Personal Representative]

_____
_____
_____
[Authority of Personal Representative]

Note to Individual: The decision of whether to accept this authorization is made solely by the person or entity whom you are authorizing to disclose information.

PHYSICIAN FORM– MEDICAL INFORMATION PART II

ALL BLANKS TO BE COMPLETED BY PHYSICIAN. If N/A, please indicate this also.

This form may be mailed or faxed to : MVNA/Camp Firefly 300 Harper Drive, Moorestown NJ 08057 Fax: (856) 552-1307, Attn: Camp Firefly

Camper's name: _____ Date of Birth _____

***PLEASE INCLUDE A CURRENT COPY OF THE IMMUNIZATION RECORD ***

TO PHYSICIAN: Your cooperation is needed in supplying the information requested below about this child, who is an applicant for attendance at Camp Firefly (a bereavement support camp). All information is confidential and for the guidance of the camp's staff and medical treatment.

CAMPER'S HEALTH HISTORY

CAMPER'S ALLERGIES

Indicate if the child is allergic to any medications, foods, animals, insects, plants, seasonal allergies, etc.

_____

_____

Describe any recent surgery or serious illness: _____

_____

Does the child require treatment at this time? (Inhalers, nebulizer or epi-pens, describe)

_____

Describe any physical disability and/or physical limitations which may restrict the child from any camp activity:

_____

PHYSICAL ASSESSMENT - NOTE ANY CONCERNS

CARDIAC _____ RESPIRATORY _____

GI _____ NEUROLOGICAL _____

GU _____ NEUROMUSCULAR _____

HEENT _____ SEIZURES _____

Parent/guardian will be notified of moderate/severe incidents. Please provide any additional information/diagnosis about this child that you feel is pertinent to this application or to his/her successful camping experience.

_____

_____

_____

----Continued----

Childs Name: _____

MEDICATIONS

Please list all medications that will be needed at camp.

MEDICATION	DOSE	ROUTE	FREQUENCY Please indicate times given or if PRN only

*** **NO MEDICATION WILL BE GIVEN UNLESS ALL INFORMATION IS PROVIDED!**
PLEASE USE SEPARATE SHEET IF NECESSARY.***

STANDING ORDERS

Please check one box in front of each order

YES	NO	
☐	☐	**FOR TEMPERATURE ABOVE 100.0 OR GENERAL MALAISE** AGES 6-8: TYLENOL LIQUID (160MG/5CC) 2 TSP PO EVERY 4 HOURS PRN AGES 9-14: TYLENOL LIQUID (160MG/5CC) 3 TSP PO EVERY 4 HOURS PRN **OR** AGES 6-8: TYLENOL JUNOR CHEWABLES (160MG) 2 PO EVERY 4 HOURS PRN AGES 9-14: TYLENOL REGULAR TABS (325 MG) 1-2 PO EVERY 4 HOURS PRN
☐	☐	**FOR HEADACHE, MINOR ACHES, DISCOMFORT FROM STINGS AND/OR CUTS** AGES 6-8: IBUPROFEN (200MG) 1 PO EVERY 6 HOURS PRN AGES 8-14: IBUPROFEN (200MG) 2 PO EVERY 6 HOURS PRN
☐	☐	**FOR MILD ALLERGIC REACTION, ITCHING, INSECT BITES** AGES 6-14: BENADRYL (25MG) CAPSULE PO EVERY 4-6 HOURS PRN **OR** BENADRYL (25MG) LIQUID PO EVERY 4-6 HOURS PRN
☐	☐	**FOR UPSET STOMACH** AGES 6-14: PEPTO BISMOL O MYLANTA LIQUID 1 TSP PO EVERY 4 HOURS PRN **OR** TUMS TABS 1-2 CHEWABLE PO EVERY 4 HOUR PRN
☐	☐	**FOR DIARRHEA** AGES 6-8: IMODIUM LIQUID, 2 MG P.O BID, NOT TO EXCEED 4 MG DAILY AGES 8-12: IMODIUM 2 MG P.O TID 1ST DAY, THEN 5 MG/ DAY, NOT TO EXCEED 6 MG DAILY
☐	☐	**FOR CUTS, INSECT BITES, ETC** BAND AIDS, GAUZE AND TAPE TOPICALLY PRN
☐	☐	BACTINE SPRAY TOPICALLY PRN
☐	☐	CALADRYL CLEAR OR SPRAY TOPICALLY TO AFFECTED AREA PRN
☐	☐	NEOSPORIN CREAM TOPICALLY TO AFFECTED AREA PRN
☐	☐	ALLERGIC INSECT BITE/STING OR ANAPHYLATIC REACTION (EPI-PENS OR ADRENALIN 0.15 MG UNDER 8 YRS/ 0.3 MG OVER 8 YRS) SQ TO AFFECTED AREA PRN AND CALL 911

DOCTOR'S STATEMENT: I HAVE EXAMINED _____, WHO IS PHYSICALLY ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT FOR PHYSICAL LIMITATIONS AND RESTRICTIONS LISTED ABOVE. I HEREBY VERIFY THE INFORMATION CONCERNING HEALTH MATTERS AND MEDICATIONS.

PHYSICIAN'S SIGNATURE:_____**DATE:**_____

ADDRESS: _____

HOSPITAL AFFILIATION: _____

PHONE NUMBER: _____

Childs Name: _____

EMERGENCY RESPONSIBILITIES FOR PARENTS/GUARDIANS

PLEASE INITIAL AND SIGN

IN CASE OF EMERGENCY:

During the course of the camp day, August 27, 2022 it may be necessary for you to return to Camp to talk to or pick up your child. We strongly recommend that you and your backup remain within two hours of travel time to the Camp on this day.

PLEASE INITIAL& SIGN THE RESPONSIBILTIES BELOW.

_____ I/We certify that someone will be available and accessible all day on August 27, 2022 to talk to, or pick up my/our child in the case of an emergency.

Signature: _____

Phone #_____

DESIGNATE A BACKUP (Required):

In case of emergency, if I cannot be reached, I designate:

(Print Name) _____

(Phone) _____

as my surrogate, and authorize them to talk to and/or pick up my child.

_____ I have informed my surrogate of their responsibilities during camp hours.

PLEASE BE ON TIME

I agree to bring my child to Camp Firefly by 8:00am and arrive to pick up my child by 7:30pm. (A brief parent meeting will be held starting at 7:30pm) on Saturday, August 27, 2022

Signature_____

LANGUAGE ASSISTIVE SERVICES

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (856) 552-1300.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (856) 552-1300.

NONDISCRIMINATION: Moorestown Visiting Nurse Association complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Moorestown Visiting Nurse Association cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Moorestown Visiting Nurse Association

遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人