



HopeHealth  
2018 Camp BraveHeart Registration Form

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Child's Age and Birthdate: \_\_\_\_\_

Child's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Child's School and Grade: \_\_\_\_\_

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

Parent/Guardian's Phone Numbers: Home: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work: \_\_\_\_\_ Emergency: \_\_\_\_\_

Name of person who died: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Was your loved one a patient with Hope Hospice & Palliative Care Rhode Island? ☐ Yes ☐ No

Age of person at time of death: \_\_\_\_\_ Date of death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Did the child live with the person who died? ☐ Yes ☐ No

Describe their relationship: \_\_\_\_\_

Specific concerns or helpful information such as aggressive behaviors or incidents, remarriage of surviving parent, relocation of child after death to another community, difficulty in school or in a relationship with others, etc. Please explain:

How do you feel your child is coping with his/her grief at this time? Please explain:

Has the child been in any support group or counseling? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

Any health problems, allergies, medications, or dietary restrictions? \_\_\_\_\_

How did you hear about the camp? \_\_\_\_\_

What do you hope your child will gain from attending camp? \_\_\_\_\_  
\_\_\_\_\_

Will your child be bringing any medicines to camp (i.e. epi-pens, inhalers, etc.)?

Please list medications here:

Is child able to self-administer: yes or no

Camp Nurse to administer: yes or no

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

Your signature indicates your permission for the camp nurse to administer medication as prescribed by a medical doctor. Medication must come to camp with pharmacy labels and correct administration instructions.

**Please check the box that best indicates your child's swimming level:**

☐ Cannot Swim      ☐ Beginner      ☐ Intermediate      ☐ Advanced

**Child's T-shirt Size (check one):**

**Youth Size:**   ☐ Small (6-8)                      ☐ Medium (10-12)                      ☐ Large (14-16)

**Adult Size:**   ☐ Small                      ☐ Medium                      ☐ Large

**Please check the box for your choice of transportation:**

- ☐ I will be taking the shuttle bus from 1689 Post Road, Warwick, RI
- ☐ I will be taking the shuttle bus from Moose Café at 1160 Stafford Road, Tiverton, RI
- ☐ I will be taking the shuttle bus from 1085 North Main Street, Providence, RI
- ☐ I will be driving my child(ren) to camp

**\*\*\*\*PLEASE READ AND SIGN\*\*\*\***

I hereby release and forever discharge Hope Hospice & Palliative Care Rhode Island and Camp Aldersgate, their employees and others associated with this program for any damages whatsoever resulting or which may result from participation the activities conducted at camp.

I give permission to Hope Hospice & Palliative Care Rhode Island and Camp Aldersgate:

- To take and use photographs of my child for brochures, articles, etc.
- To treat my child with emergency medical care/first aid if necessary.

Parent or guardian's name:

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Parent or guardian's signature:

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**Please mail this form to:**

Attn: Sarah Cordeiro  
HopeHealth  
1085 North Main Street  
Providence, RI 02904

**The cost of the camp is FREE.** If you would like to make a donation to this worthy cause, please include your check with this registration form or visit [HopeHealthCo.org/DonateNow](http://HopeHealthCo.org/DonateNow). Your contributions are appreciated.

**Children ages 5 and 6 years old MUST be accompanied by a parent or guardian. Space is limited. Deadline for registration is July 13.**

For more information, contact Sarah Cordeiro, Grief Counselor at Hope Hospice & Palliative Care Rhode Island, at [SCordeiro@HopeHealthCo.org](mailto:SCordeiro@HopeHealthCo.org) or call our Camp BraveHeart registration/information line at (401) 415-4610.

