

Camp Erin® Los Angeles 2019 Camper Application



Attach a photo of
your child/teen here

Camp Information

Please indicate which camp session you are applying to:

- Session 1: June 7 – June 9, 2019
 Session 2: September 6 – September 8, 2019

Has your child attended Camp Erin before? Yes No

If **Yes**, was it Camp Erin Los Angeles? Yes No

Has your child participated in an OUR HOUSE grief support group?

- Yes, In-House Group Yes, School Group No

PROSPECTIVE CAMPER INFORMATION

A separate application must be completed for each Prospective Camper

Camper First Name _____ Last Name _____

Name the Camper prefers to be called (if different from above) _____

Swim Level (please mark one) Non-Swimmer Beginner Advanced

Camper T-Shirt Size (please mark one) Youth Sizes S M L
Adult Sizes S M L XL XXL XXXL

Camper has: (please mark all that apply)

Attended Day Camp Attended Overnight Camp Spent the night away from home

Primary Language _____ Date of Birth (mm/dd/yyyy) _____

Grade _____ School _____

Age _____ Will Camper have a birthday before camp? Yes No

Gender Female Male Non-Binary Camper Identifies As _____

Please describe the Camper's personality/character traits _____

Please list the Camper's interests and hobbies _____

Which **best** describes the Camper's reaction to the possibility of attending Camp Erin LA?

Excited Resistant Unsure/Mixed Feelings They have not been told about Camp Erin LA

Camper's Siblings: Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Camper Name _____

Signature _____ Date _____ Relationship to Camper _____

PROSPECTIVE CAMPER HEALTH INFORMATION

| Mark any of the following that apply to the Camper. | Yes | No |
|---|-----|----|
| Asthma | | |
| Convulsions / Seizures | | |
| Diabetes | | |
| Chronic Ear Infections | | |
| Hearing Impairment | | |
| Motion Sickness | | |
| Nosebleeds | | |
| Wears Glasses/Contacts | | |
| Recurring Headaches or Stomachaches | | |
| Other: <i>(please specify)</i> | | |
| Does the Camper have any special needs, physical limitations, diagnosed mental illness, and/or developmental/learning disabilities (IEP, OT services)? If Yes , please explain. | | |
| Does the Camper have any history of operations or serious illnesses? If Yes , please explain. | | |
| Does the Camper have any dietary restrictions? <i>(physician recommended, religious, etc.)</i> If Yes , please list below. | | |
| Does the Camper have any allergies? <i>(to food, medicine, environment, seasonal, etc.)</i> If Yes , please list below. | | |
| Will the Camper be taking medications at camp? If Yes , please list the medications and what they are treating. | | |

Camper Name _____

Signature _____ Date _____ Relationship to Camper _____

PARENT/LEGAL GUARDIAN INFORMATION

It is preferred for the Prospective Camper's Parent/Legal Guardian to complete the application, even if with support. The Parent/Legal Guardian is required to at minimum, review and sign the application.

Parent/Guardian First Name _____ Last Name _____

Phone # (home/cell/work) _____

Email _____

Home Address _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

Have you participated in an OUR HOUSE grief support group for yourself? Yes No

*If the person completing this application is **NOT** the Camper's Parent/Legal Guardian:*

Your First & Last Name _____

Relationship to Camper _____

Phone # _____ Email _____

Have you spoken with the Camper's Parent/Legal Guardian about Camp Erin LA?

Yes No

Did the Parent/Legal Guardian consent to you completing this application on their behalf?

Yes No

Comments

Emergency Contacts:

Please list two people other than yourself that we can contact in case of an emergency at camp.

Name _____ Relationship to Camper _____

Phone # _____

Name _____ Relationship to Camper _____

Phone # _____

How did you learn about Camp Erin LA? (please mark all that apply)

OUR HOUSE Staff/Board Member School Family Member/Friend

Former Camper/Volunteer Medical/Mental Health Professional

Eluna Website Newspaper/Magazine Television Radio Internet Search

OUR HOUSE Newsletter OUR HOUSE Social Media OUR HOUSE Website

"One Last Hug" Documentary Other _____

Would you like to receive communication about OUR HOUSE Grief Support Center programs and events? Yes No

Camper Name _____

Signature _____ Date _____ Relationship to Camper _____

BEREAVEMENT & FAMILY HISTORY

We understand that these questions may be difficult to answer. This information helps us to better support your Camper in their grief and provide the best possible care.

Please tell us about the person the Camper is grieving.

First & Last Name of the Person Who Died

What the Camper called their Person Who Died

Relationship to Camper (please mark all that apply)

- Father Mother Brother Sister Grandfather Grandmother Uncle Aunt
 Cousin Primary Caregiver Friend Other: _____

Date of Death (mm/dd/yyyy) _____

Person Who Died's Age at Time of Death _____ **Camper's Age at Time of Death** _____

Cause of Death

The death was: Anticipated Sudden

Where did this person die? _____

Was the Camper present at the time of death? Yes No

Did the Camper see their person who died, after the death? Yes No

Did the Camper attend the funeral / memorial service, if one was held?

Yes No

If **Yes**, what were your Camper's reactions to/comments about the service?

Please mark if either statement applies to your Camper:

- Camper has **NOT** been told the facts about the cause of death
 Camper does **NOT** understand the facts about the cause of death

If you marked one of the above, please explain _____

Please note: It is in your Camper's best interest to know the true cause of death. Therefore, it is a requirement of Camp Erin LA that Campers know the true cause of death if it is known to the family. Camp Clinical Staff are available to assist you if you need to have this conversation with your Camper.

Did the Camper live with their person who died? Yes No

Camper Name _____

Signature _____ Date _____ Relationship to Camper _____

If **No**, please describe what type of contact and how frequently the Camper was in contact with their person who died.

Please describe the Camper's relationship with their person who died.

How did the Camper react to the death?

How would you describe the Camper's communication regarding the death?

Open Minimal Avoidant

How would you describe the Camper's family's communication regarding the death?

Open Adequate Minimal Avoided None

Please describe how the Camper indicates they are grieving.

Is this the Camper's first experience with death? Yes No

If **No**, please explain the other deaths the Camper has experienced, including (1) Who died (2) Date of Death (3) Cause of Death.

Is the Camper displaying any behaviors and/or moods that concern you?

Yes No

If **Yes**, please explain _____

Camper's Reaction to the Death

Please mark any of the following that the Camper has exhibited since the death(s) of their significant person(s).

Physical Changes

Headaches/Stomachaches Lack of Energy Encopresis Loss of Interest in Usual Activities

Change in Appetite/Weight (*please specify*) Difficulty Concentrating

Increase Decrease

Change in Sleep (*please specify*)

Increase Decrease Bedwetting Nightmares Night Terrors Sleepwalking

Camper Name _____

Signature _____ Date _____ Relationship to Camper _____

Thoughts & Feelings

- Anger
- Depression
- Sadness
- Special Fears
- Disbelief
- Withdrawn/Isolated
- Worries About Safety/Death of Self and Others
- Guilt/Regret
- Separation/General Anxiety
- Change in Self-Perception
- Happy Memories
- Trying to Be Perfect or Always in Control
- Suicidal Thoughts/Talk
- Belief that Death is a Punishment
- Belief that Death was their Fault

Behaviors

- Inappropriate Sexual Behavior
- Lying
- Stealing
- Self-Harm
- Drug/Alcohol Use
- Suicide Attempts
- Hyperactive/Impulsive
- Destruction of Property
- Causing Harm to Others
- Change in School Attendance or Grades *(please specify)*
- Increase Decrease
- Peer Difficulties
- Running Away
- Behavior Problems at School
- Behavior Problems at Home

Have there been any other changes or stressors in the Camper's life? Yes No
(physical or mental illness, change of school/home, divorce/remarriage, financial strain, other losses, etc.)

If **Yes**, please explain _____

Has the Camper ever witnessed or experienced violence of any kind? Yes No

If **Yes**, please explain _____

Has the Department of Child and Family Services ever been notified about the Camper's family? Yes No

If **Yes**, please explain _____

Has the Camper ever been removed from their home due to abuse or neglect of any kind?

Yes No

If **Yes**, is there currently an open case with the Department of Child and Family Services? Yes No

Has the Camper received any professional support? Yes No

If **Yes**, please mark all that apply.

- School Counseling Psychiatry Individual Therapy Family Therapy Pastoral Support
- Peer Support Group or Group Counseling Grief Camp Other _____

If **Yes**, what was the reason for Camper receiving services?

Is the Camper currently connected to support/services? Yes No

If **Yes**, please list what type of support/services and length of time received.

Camper Name _____

Signature _____ Date _____ Relationship to Camper _____

Please explain any family customs, religious/faith practices or cultural aspects to the Camper's grieving that we should be aware of to better support them.

Anything else you would like us to know?

The questions in this section are used only for demographic statistics.

Family Income

Of People in Household _____ # OVER Age 18 _____ # UNDER Age 18 _____

- Less than \$25,000
- \$25,000 to \$34,999
- \$35,000 to \$36,899
- \$36,900 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 +
- Decline to Answer

Camper Race/Ethnicity (please mark all that apply)

- African American Asian Caucasian Hispanic/Latino/a/x Native American
- Pacific Islander Multi-Race/Ethnic Other _____ Decline to Answer

Is the Camper's Parent/Guardian and/or the person who died affiliated with the military as active duty, reserve, or veteran? Yes No Decline to Answer

If **Yes**, please mark which branch(es)

- Army Navy Marine Corps Air Force Coast Guard National Guard

Please return your completed application by
May 15, 2019 for the June session of camp and
August 14, 2019 for the September session of camp to:

By Mail:

OUR HOUSE Grief Support Center
Attn: Talya Schlesinger / Camp Erin
1663 Sawtelle Blvd.
Suite 300
Los Angeles, CA 90025

By Fax: (310) 473-1515, Attn: Talya Schlesinger/Camp Erin

By Email: Talya@ourhouse-grief.org

If you have any questions regarding Camp Erin LA or the application process, please contact Talya Schlesinger, Associate Clinical Coordinator of Camp, at (424) 220-6634.

Camper Name _____

Signature _____ Date _____ Relationship to Camper _____