

# Wings to Soar Camp Application

## CHILD/TEEN REGISTRATION

\*\*\*Pre-registration for Wings to Soar Camp is required\*\*\*

Application will be denied if not filled out completely.

For each child who will be attending, please send this completed registration form to:

Shea.Collins@AtriumHealth.org or mail it to:

Hospice & Palliative Care of Cabarrus County - (Attn: Wings to Soar) - 5003 Hospice Ln, Kannapolis, NC 28081

### CAMPER INFORMATION

Name: \_\_\_\_\_  
Last First MI

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Prefers to be called: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Camper T-shirt Size: Adult / Child (Circle One) Small / Medium / Large / XL / XXL (Circle One)

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Does camper receive any accommodations in the classroom that would benefit them at camp?

Have there been any difficulties in the classroom this year?

### PARENT INFORMATION

\*Parents/guardians are recommended to participate in the adult session while the child is at camp.

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Contact information for parent living away from primary home:

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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WINGS  
TO SOAR



IKE'S  
CONSTRUCTION, INC.



Atrium Health

# Wings to Soar Camp

## Children's Medical Information

Please complete both sides of this form.

**NOTE:** This form is given to and reviewed by our camp nurse, therefore must be filled out in its entirety prior to acceptance of camper application.

### MEDICAL INFORMATION

List any physical or mental concerns your child may have: \_\_\_\_\_

\_\_\_\_\_

Are there any activities that should be restricted? \_\_\_\_\_

\_\_\_\_\_

List any medications that are taken. (If necessary, medications will be dispensed by the Camp Nurse).

Medication Taken

Dose

Time Taken

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any allergies that we should know about (ex. Hay Fever, Insect Stings, Penicillin, Asthma etc.):

\_\_\_\_\_

List any food allergies or diet restrictions:

\_\_\_\_\_

Are there any sleeping or eating challenges since the loss?

\_\_\_\_\_

Is camper up to date with all immunizations? \_\_\_\_\_

Health Insurance: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_

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## IN CASE OF EMERGENCY, THE CAMP SHOULD NOTIFY

If the parent/guardian is not available in event of an emergency, please notify:

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Secondary responsible party to notify in case we cannot reach the person listed above:

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Practice: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

### IMPORTANT --THIS SECTION MUST BE COMPLETED FOR ATTENDANCE!!

This health history is correct as far as I know, and the child herein described has my permission to engage in all prescribed camp activities except those expressly noted herein.

### AUTHORIZATION FOR TREATMENT:

*I hereby give permission to the camp medical personnel to release medical history information, to contact the primary care physician and/or dentist, and/or to provide or arrange related transportation for my child named herein in case of emergency to the nearest medical facility. In the event, I cannot be reached in an emergency, I hereby give permission to the camp medical personnel to secure and administer treatment, including hospitalization for my child. I understand that no accident or medical insurance is provided and agree that I will be financially responsible for any medical treatment received by my child.*

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

### LIABILITY RELEASE:

*I hereby release Wings to Soar Camp, Hospice & Palliative Care of Cabarrus County and its parent, predecessors, successors, subsidiaries, assigns, affiliates, related entities, divisions, directors, officers, commissioners, members, employees, volunteers, agents, attorneys, representatives, heirs and assigns from and against any and all claims, damages, liability, costs, or demands, arising from or relating to my child's participation in Wings to Soar Camp including, without limitation, any personal injury or property damage that my child may sustain, however caused and whenever realized.*

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

# CAMPER LOSS

Name of deceased person: \_\_\_\_\_

Relationship of deceased to child: \_\_\_\_\_

Was deceased a Hospice & Palliative Care of Cabarrus County patient? ☐ Yes ☐ No

Did the child live with the deceased? ☐ Yes ☐ No

Date of death: \_\_\_\_\_ Deceased age at death: \_\_\_\_\_

Type of death: ☐ Accident ☐ Long term illness ☐ Short term illness ☐ Traumatic (Murder/Suicide)

Please explain: \_\_\_\_\_

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Was the child present with the deceased at the time of death: ☐ Yes ☐ No

Other significant losses/changes in the past 2 years: \_\_\_\_\_

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How is camper in a group setting?

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What do we need to know about your camper so that we can best work with them?

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Is there anything else you want us to know ?

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