The Moyer Foundation and
Roberta's House

Camp Erin Baltimore

Roberta's HOUSE
A Family Grief Support Center

*****PLEASE PRINT LEGIBLY*****

NAME: _____ **ID:** _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Parent/Legal Guardian: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone: _____

Have you attended Camp Erin in the Past: ___ No ___ Yes, what year: _____

Child's T-Shirt Size: ☐ Youth ☐ Adult ☐ XS ☐ S ☐M ☐L ☐XL ☐XXL

Rev 2/2017

Internal Use Only
Date Rec'd _____
Initials _____

Child's Name: _____ Child's Date of Birth: _____

Nick Name: _____ Age: _____ Gender: _____

Child's Phone #: _____ Race: _____

Primary Language: _____ Religious Affiliation: _____

CHILD/TEEN CAMP INFORMATION

1. Have you and your child talked about the possibility of him/her coming to Camp Erin to address their grief? ___ Yes ___ No
2. Has your child ever:
   - Attended day camp? ___ Yes ___ No
   - Attended overnight camp? ___ Yes ___ No
   - Spent the night away from home? ___ Yes ___ No
3. Explain your child's past camp experience(s) ___ Good ___ Not so good

   If not so good, please explain: _____
4. What is your child's most and least favorite food(s)? _____

   _____
5. Please list any special interest/hobbies your child has: _____

   _____
6. What would you hope that your child would gain from attending Camp Erin? _____

   _____

SCHOOL/EDUCATIONAL INFORMATION

School attending: _____ Grade: _____ _____

1. Does your child receive special services (e.g., IEP services tutoring)? ___ Yes ___ No

   If yes, check IEP services: ___ counseling ___ instruction ___ speech/language ___ OT/PT
2. Does your child attend home school? ___ Yes ___ No

   If yes, explain: _____
3. Does your child have any disabilities or impairments? (Check all that apply) ___ None ___ Learning
   ___ Speech ___ Visual ___ Behavioral ___ Emotional ___ Mathematical ___ Motor
   ___ Language (reading/writing) Other (please specify): _____
4. Has your child ever repeated a grade? ___ Yes ___ No
5. Will your child need assistance reading or writing on their grade level? ___ Yes ___ No
6. Has the child ever been expelled from a school? ___ Yes ___ No

   If no, explain: _____

Child's Name: _____

MEDICAL INFORMATION

Does your child have any of the following:	Yes	No
Asthma		
Diabetes		
Convulsions/Seizures		
Ear Infections		
Hearing Impairment		
Motion Sickness		
Nosebleeds		
Wears Glasses/Contacts		
Recurring headaches or stomach aches		
Dietary Restrictions (i.e. physician recommended, religious, etc.)		
If yes, please explain:		
Physical Limitations: *(please explain)*		
Is your child currently under the care of a physician?		
Physician's Name: Phone #:		
Does your child have any allergies? (i.e. food, medicine, or other)		
If yes, please explain:		
Any history of operations, hospitalizations or serious illnesses?		
If yes, please explain:		
Does the child have any disability or handicap?		
If yes, please specify:		
Will your child be taking medications at camp?		
If yes, please fill out the "Consent for Medical/Surgical Care, Emergency Treatment and Medical" form		
Most current Tetanus and immunization shot? Date:		

(Additional) If yes to the above please explain :

_____

_____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO CHILD: _____ EMAIL: _____

HOME PHONE: _____ CELL PHONE: _____

Is there a hospital that your insurance mandates: _____

HOSPITAL OF CHOICE: _____

MEDICAL INSURANCE: _____ POLICY #: _____

Child's Name: _____

BEREAVEMENT HISTORY

Please include as many details as possible when answering the following questions. We understand that answering some of these questions might be difficult; however, we want to be able to provide the best possible care for your child.

1. Full name of the deceased: _____
2. Relationship to the child: _____
3. Birth date of deceased: _____ Date of death: _____
4. Age of deceased at time of death: _____ Age of child at time of death: _____
5. Was the deceased receiving Hospice services at the time of death? ___ Yes ___ No
6. Was the death anticipated or sudden? ___ Anticipated ___ Sudden
7. What was the deceased's cause of death? ☐ Natural causes ☐ Homicide ☐ Cancer ☐ Suicide
   ☐ Stroke ☐ Military ☐ Drowning ☐ Motor Vehicle ☐ Prenatal death ☐ Heart Disease
   ☐ Drug and alcohol abuse/overdose ☐ Other: _____
8. Please check if either of the following statements are true:
   a. ____ Child has **not** been told the facts about the deceased's cause of death
   b. ____ Child does **not** understand the facts about the deceased's cause of death

   If either is checked, please explain: _____

   _____
9. Is this your child's first experience with death? ___ Yes ___ No

   If no, please comment on other deaths your child has experienced: _____

   _____
10. Where did this person die? _____
11. Was the child present at the time of death? ___ Yes ___ No
12. Did the child see the deceased after the death? ___ Yes ___ No
13. Was there a funeral or memorial service? ___ Memorial Service ___ Funeral ___ No
    a. Did your child attend? ___ Yes ___ No
    b. Where were the services held: _____
    c. What were your child's comments/reactions to the service? _____
    d. Did the child live with the deceased? ___ Yes ___ No
14. How would you describe your child's relationship with the deceased? _____

    _____
15. Does your child speak openly of the person who died? ___ Yes ___ No

Child's Name: _____

16. How would you describe your family's communication style regarding the death?

___ A lot ___ Sometimes ___ Very little ___ Avoided ___ None

17. Please explain how your child shows that he/she is grieving: _____

_____

MENTAL HEALTH INFORMATION

1. Has your child received any professional support (i.e. school counselor, mental health therapist, peer support group, psychiatrist, and pastoral support)? ___ Yes ___ No
   a. If yes, is support currently provided ___ Yes ___ No
   b. Please give approximate dates of support start: _____ end: _____
2. Past Experiences (check all that apply): ☐ Death of a Pet ☐ Personal Illness ☐ Neglect
   ☐ Foster Care ☐ Emotional Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐ Victim of Rape
   ☐ Caregiver divorce/separation ☐ Relocation to New House/Community ☐ Witness of a Murder
   ☐ Victim or Witness of a Violent Crime ☐ Victim or Witness of a Domestic Violence
   ☐ Other (please specify): _____
   Please explain the above checked: _____
   _____

REACTION TO THE LOSS

Please place an "X" if your child has exhibited any of the following since the death of the loved one:

☒ Lying ☐ Sadness ☐ Stealing ☐ Disbelief ☐ Depression ☐ Anger ☐ Special fears
☐ Peer Difficulties ☐ Drug/Alcohol Use ☐ Suicidal thoughts/talk/attempts ☐ Withdrawn/Isolation
☐ Hyperactive/Impulsive ☐ Destruction of Property ☐ Causing harm to self ☐ Causing harm to others
☐ Running away from home ☐Behavior problems at school ☐ Lack of energy ☐ Behavior problems at home
☐ Headaches, stomach aches ☐ Difficulty with concentration ☐ Changes in weight (Circle: Increase/Decrease)
☐ Inappropriate sexual behavior ☐ Loss of interest in usual activities ☐ Belief that death was his/her fault
☐ Changes in how he/she feels about self ☐ Worries about his/her safety or the safety of others
☐ Always trying to be in control or perfect ☐ Changes in attendance at school (Circle: Increase/Decrease)
☐ Belief that death is a punishment ☐ Sleeping disturbances (Circle: sleep walking, bed wetting, nightmares, night sweats)

1. Please explain the above checked: (please include behavioral/ mood changes) _____
   _____
2. Please describe your child's personality/character traits: _____
   _____
3. Is there anything we should know to better serve your child? _____
   _____
4. Are there any religious needs, family customs, or cultural aspects to your child's grieving that we should be aware of?
   _____

Child's Name: _____

MILITARY AFFILIATION

The Moyer Foundation (TMF) is actively working to increase awareness that Camp Erin is a resource to those in the military community (active, reserve, National Guard and veteran) – for all loss types, not limited to military casualties.

1. Was the deceased an active, reserve, or National Guard military member or military Veteran?

Yes, what branch? _____ No ___

2. Is either parent or guardian an active, reserve or National Guard military member or military Veteran?

Yes, what branch? _____ No ___

FAMILY INCOME

**** For grant purposes, Roberta's House needs to collect the joint annual income of the adults in the home. ****

Number of persons in the household: _____

Annual Income:

☐ Below $5,000 ☐ $5,001-$10,000 ☐ $10,001-$15,000

☐ $15,001-$20,000 ☐ $20,001-$25,000 ☐ $25,001-$30,000 ☐ $30,001-$35,000

☐ $35,001-$40,000 ☐ $40,001-$45,000 ☐ $45,001-$50,000 ☐ Over $50,001

How did you learn about this program? ☐ Roberta's House ☐ Funeral Home ☐ Radio Advertisement

☐ Newspaper ☐ Hospice ☐ School ☐ Physician ☐ Friend ☐ Other: _____

_____ _____

Signature **Date**

Relationship to child (please print legibly): _____

Mail to:

Camp Erin Baltimore
C/O Roberta's House, Inc.
2510 St. Paul Street, 1st Floor
Baltimore, Maryland 21218
Fax to: 410-235-6636
Email to: info@robertashouse.org and place Camp Erin in the subject line