The Moyer Foundation and
Roberta's House

Camp Erin Baltimore

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

NAME: ____ **ID:** ______________________

Address: ____

City: ____ State: ____________ Zip: __________

Name of Parent/Legal Guardian: ____

Phone: ________________________ Email: ____

Emergency contact: ________________________________ Phone: _____________________

Has your child ever attended a Roberta's House Grief Support Group: ___ No ___ Yes,
What program and year: ________________________

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

Internal Use Only
Date Rec'd ______________
Initials ______________

Camp Erin Baltimore

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: ____

Camp Erin Baltimore

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 #: _____________________

Camp Erin Baltimore

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