Dear Parent/Guardian,

Thank you for interest in Roberta's House Camp Erin® Baltimore. Camp Erin is a 3-day weekend overnight camp filled with traditional camp activities combined with grief education and emotional support for young people ages 6-17. Camp Erin Baltimore is held annually in August at NorthBay Adventure Camp in Cecil County, Maryland. Visit our website for more information about camp. https://robertashouse.org/programs/children-teens/camp-erin/.

This year camp will be held August 14th-16th 2020. Families interested in sending a young person to camp are asked to complete the enclosed application and participate in an interview. The application and the interview are used to determine whether camp will be appropriate for the young person. For some children, this will be the first time they are away from their families for a weekend overnight.

The deadline for completed applications is May 31st, 2020. Space is limited and spots fill quickly. Please be prompt in returning your application. After the completed application is received, Roberta's House staff will contact the family within 2 weeks to schedule the in-person interview for the potential camper and their parent/guardian. Scheduling for interviews will begin the first week of March. Completion of an interview does not automatically guarantee a space for camp. Careful consideration is taken to ensure each potential camper will have a successful camp experience. Families will be notified of camp acceptance by mail no later than 2 weeks after the completion of the interview.

We are very excited and looking forward to another wonderful camp experience! If you have any questions or concerns regarding camp or the process to apply, please do not hesitate to contact us at CampErin@robertashouse.org.

Sincerely,
Allyson Lother, MSW
Special Projects Coordinator
410-235-6633 x 125
alother@robertashouse.org
***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
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 yes, explain: ____________________________________________
# MEDICAL INFORMATION

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

__________________________

__________________________

__________________________

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**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. Was the deceased a significant caregiver of the camper? ___ Yes ___ No
4. Birth date of deceased: __________________________ Date of death: __________________________
5. Age of deceased at time of death: ____________________ Age of child at time of death: __________
6. Was the deceased receiving Hospice services at the time of death? ___ Yes ___ No
7. Was the death anticipated or sudden? ___ Anticipated ___ Sudden
8. 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: _________________________________
9. 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: ________________________________________________
10. Is this your child’s first experience with death? ___ Yes ___ No

    If yes, please comment on other deaths your child has experienced: ______________________
11. Where did this person die? _________________________________
12. Was the child present at the time of death? ___ Yes ___ No
13. Did the child see the deceased after the death? ___ Yes ___ No
14. 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
15. How would you describe your child’s relationship with the deceased? ______________________
16. Does your child speak openly of the person who died?  
___ Yes  ___ No

Child’s Name: ____________________________________________________________________________________________

17. How would you describe your family’s communication style regarding the death?
   ___ A lot  ___ Sometimes  ___ Very little  ___ Avoided  ___ None

18. 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/attempt  □ 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

Eluna 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. ****

1. Number of persons in the household: ________________

2. Does the camper qualify for or receive free or reduced lunch at school? Yes___ No___

3. Head of Household: MALE or FEMALE

4. Number of Persons in the household with disabilities: # __________

Annual Income: □ Below $5,000 □ $5,001-$10,000 □ $10,001-$15,000
□ $15,001-$18,050 □ $19,950-$22,800 □ $22,801-$25,650 □ $25,651-$28,450
□ $28,451-$30,750 □ $30,751-$33,250 □ $33,251-$38,000 □ $38,001-$42,750
□ $42,750-$47,450 □ $47,451-$51,250 □ $51,251-$55,050 □ Over $60,000

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: CampErin@robertashouse.org and place Camp Erin in the subject line