



Hospice of Ashland County  
Hospice of Knox County  
Hospice of Richland County  
Life's Seasons Palliative Care  
What Goes 'Round Thrift Shoppe

### Camp Hope 2019 Registration Form

**Ages 6-11: Monday, June 17 at 9 am to Wednesday, June 19 at 9 am (Overnight two nights)**  
**Ages 12-17: Wednesday, June 19 at 11 am to Friday, June 21 at 11 am (Overnight two nights)**

Pleasant Hill Outdoor Camp  
4654 Pleasant Hill Road, Perrysville, Ohio 44864

Please submit this completed form, signed by parent/guardian, along with \$30 registration fee made payable to Hospice of North Central Ohio, to: Camp Hope Registration, 17700 Coshocton Road, Mount Vernon, OH 43050  
Registration fee waivers are available as needed.

Camper's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_  F  M

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Parent/Guardian's Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Parent/Guardian's Email \_\_\_\_\_

Name of person camper is grieving \_\_\_\_\_ Relationship \_\_\_\_\_

How long ago? \_\_\_\_\_ Cause or circumstances of death \_\_\_\_\_

Did camper live with this person? Please circle: Yes No

Did child witness death? Please circle: Yes No

Are there any specific concerns or other pertinent information that we should know? (For example, inappropriate or aggressive behaviors, mood disturbances, etc.)

Your expectations of Camp Hope for your child:

Circle camper's T-shirt size: Youth S Youth M Youth L Adult S Adult M Adult L Adult XL

**Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Family Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Please list all pertinent medical information including allergies, medications, restrictions, etc.\*

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\*Please note: A nurse will meet with each child and parent to review medications and any special conditions.

Please check one:

Do apply sunscreen and bug repellent as appropriate.

Do not apply sunscreen and bug repellent as appropriate.

**MEDICAL RELEASE**

My child \_\_\_\_\_ has permission to participate in all activities of Camp Hope, with the exception of restriction listed above. I understand that the participants will be supervised. I understand that employees and volunteers of Hospice of North Central Ohio are not responsible in the event of accidental injury or illness, nor for compounded injury or illness due to the camper's medical conditions listed. I further understand that in case of serious injury or illness, I will be notified. I give my permission for my child to be transported to the nearest hospital facility. If I cannot be contacted, I give permission to the family physician or to the emergency room physician to hospitalize, secure proper treatment, and order injection, anesthesia, or surgery for the participant as named above.

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Parent/Guardian Signature

Date

**RELEASE OF LIABILITY**

I understand and agree that Hospice of North Central Ohio and its Board of Directors, officers, employees, volunteers and camp sponsors, are released from any legal responsibility and/or liability for negligence arising out of any accident or illnesses that may occur while my child (name of camper on form) or I attend Camp Hope.

**RELEASE OF PUBLICITY**

I give permission to Hospice of North Central Ohio to use photographed, voice and video images of the camper named above, and of any activities in which the camper is involved, in print, social media, online and other publicity.

I **DO NOT** give permission to Hospice of North Central Ohio to use photographed, voice and video images of the camper named above, and of any activities in which the camper is involved, in print, social media, online and other publicity.

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Parent/Guardian Signature

Date

**Send completed form to: Camp Hope Registration, 17700 Coshocton Road, Mount Vernon, OH 43050**

*Hospice of North Central Ohio, Inc. does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, national origin, disability, sex, sexual orientation, gender identity, religion, creed, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, and in staff and employee assignments to patients, whether carried out by Hospice of North Central Ohio, Inc. directly or through a contractor or any other entity with which Hospice of North Central Ohio, Inc. arranges to carry out its programs and activities.*

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**For Office Use Only**

Amount Paid \_\_\_\_\_ Scholarship \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_