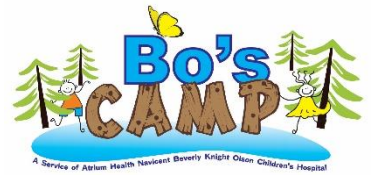


**Bo's Camp Child Application**  
**September 27-29, 2024**



**INSTRUCTIONS: Complete this form in its entirety. Parent or legal guardian signature is required on this application.**  
Email to [BosCamp@atriumhealth.org](mailto:BosCamp@atriumhealth.org) or mail to 777 Hemlock Street MSC 38, Macon, GA 31201. If you have questions or need assistance, contact 478-633-1503. Registration includes all food & activities for the day. Bo's Camp is free of charge to each camper. Parent or Guardian **MUST** attend with camper.

**Child Camper Name (Fill Out One Application Per Child):**

\_\_\_\_\_  
(First Name & Nickname if used) (M.I.) (Last)

**Relationship of Adult (s) To Child Attending:** \_\_\_\_\_

**Address:**

Street: \_\_\_\_\_  
City: \_\_\_\_\_  
Zip code: \_\_\_\_\_

**Phone Numbers:**

Home: (\_\_\_\_\_) \_\_\_\_\_  
Parent/Guardian Work Number: (\_\_\_\_\_) \_\_\_\_\_  
Parent/Guardian Cell Number: (\_\_\_\_\_) \_\_\_\_\_

**Email address for family/parent or guardian:** \_\_\_\_\_

**Child's T-Shirt Size:**

Youth Sizes: ☐ S (6 – 8) ☐ M (10 – 12) ☐ L (14 – 16) Adults Sizes: ☐ S ☐ M ☐ L ☐ XL

**General Information:**

Age: \_\_\_\_\_ School Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Sex: ☐ Male ☐ Female Race: ☐ White ☐ African American ☐ Hispanic ☐ Other: \_\_\_\_\_

What school does your child attend? \_\_\_\_\_

**Emergency Contact Information:**

Please list the name of 2 persons you would like us to contact in case of an emergency.

Name	Phone Number	Relationship to child
Contact # 1: _____	_____	_____
Contact # 2: _____	_____	_____

**Insurance Information:**

**Insurer Name** \_\_\_\_\_

**Carrier:** ☐ Medicare ☐ Medicaid ☐ Blue Cross/Blue Shield ☐ Tricare ☐ HMO

☐ Other Commercial Name: \_\_\_\_\_

☐ Insurance # \_\_\_\_\_

**Medical History**

**Pediatrician/Family Physician:** \_\_\_\_\_ **Phone** \_\_\_\_\_

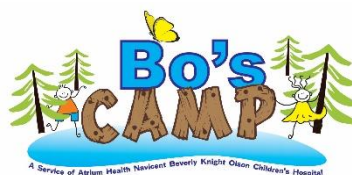
<b>MEDICAL INFORMATION</b> <b>Significant Allergies (specify)</b> <input type="checkbox"/> Insect Sting: _____ <input type="checkbox"/> Medicine/Drug: _____ <input type="checkbox"/> Plant/Pollen: _____ <input type="checkbox"/> Other: _____  Recent surgery or hospitalization? _____  Immunizations Current? <input type="checkbox"/> YES <input type="checkbox"/> NO  COVID Vaccine <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>LIST OF CURRENT MEDICATIONS</b> <b>**Medicine:</b> _____ _____ _____  <b>Check all that apply, explain:</b> <input type="checkbox"/> Asthma: _____ <input type="checkbox"/> ADD: _____ <input type="checkbox"/> ADHD: _____ <input type="checkbox"/> Diabetes: _____ <input type="checkbox"/> Seizures: _____ <input type="checkbox"/> Stomach Conditions: _____ <input type="checkbox"/> Heart Conditions: _____ <input type="checkbox"/> Other: _____
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### **FOOD AND DIET INFORMATION**

#### **Significant Allergies (specify)**

I have the following food allergies: \_\_\_\_\_

Please specify any diet restrictions: \_\_\_\_\_



## Child Bereavement History

Please include as many details as possible when answering the following questions this assists our staff in planning. Feel free to write on the back of this form or attach additional pages if necessary.

1. Who was the person(s) who died (name): \_\_\_\_\_
2. Age(s) \_\_\_\_\_
3. Cause of death? \_\_\_\_\_
4. How was the person related or associated to the child? \_\_\_\_\_
5. When did the death occur? (date) \_\_\_\_\_
6. Age of your child when the death occurred: \_\_\_\_\_
7. Where did this person die? ☐ Home? ☐ Hospital? ☐ Other  
Please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Was the child present at the time of death? ☐ Yes ☐ No  
Explain the circumstances if child was present at time of death.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Did the child attend the funeral/memorial service? ☐ Yes ☐ No  
If yes, what was your child's reaction to the service? What were their comments about it?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Has your child received any professional support to help with the grieving process?  
(i.e., school counselor, peer support group, psychologist, psychiatrist, pastoral counselor)  
☐ Yes ☐ No  
If yes, is support currently being provided to your child? ☐ Yes ☐ No  
If counseling is no longer in progress how long was the period of support provided?  
\_\_\_\_\_  
\_\_\_\_\_

11. Please explain how your child indicates that he/she is still grieving? Anger, isolation?

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12. Have there been multiple deaths of loved ones experienced by this child?

☐ Yes ☐ No

If yes, please describe the nature of death and the child's relationship to the person that died.

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13. Have there been any other changes or stresses in your child's life?

(i.e., divorce, remarriage, relocation, illness, etc.)

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14. Please list or explain any information you would like to share about your child and the way they handled the recent loss of their family member or friend.

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15. Any suicide attempts? If yes, please explain:

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\_\_\_\_\_  
Print name of parent/guardian

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date