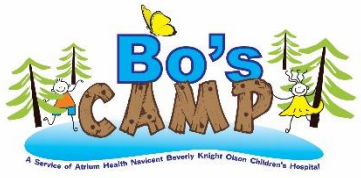
Atrium Health Navicent
Beverly Knight Olson Children's Hospital

Bo's Camp Adult Application
September 27-29, 2024



INSTRUCTIONS: Complete this form in its entirety. Email to BosCamp@atriumhealth.org or mail to 777 Hemlock Street MSC 38, Macon, GA 31201. If you have questions or need assistance, call 478-633-1503. Registration includes food & activities for the day. Bo's Camp is free of charge to each camper. ONLY COMPLETE APPLICATIONS WILL BE ACCEPTED. One camper per application.

Adult Camper Name:

_____ _____ _____
(First Name & Nickname) (M.I.) (Last)

Name of Child/Children and Relationship to Child Attending Camp:

_____
_____
_____

Address:
Street: _____
City: _____
Zip code: _____
Email address: _____

Phone Numbers:
Home: (_____) _____
Work Number: (_____) _____
Cell Number: (_____) _____

T-Shirt Size:
Adult: ☐ S ☐ M ☐ L ☐ XL ☐ XXL ☐ XXXL ☐ XXXXL

General Information:
Age: _____ Date of Birth: _____ / _____ / _____
Sex: ☐ Male ☐ Female
Race: ☐ White ☐ African American ☐ Hispanic ☐ Other

How did you hear about Bo's Camp? _____

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
Family Physician: _____ **Phone (___)** _____

MEDICAL INFORMATION **Significant Allergies (specify)** ☐ Insect Sting: _____ ☐ Medicine/Drug: _____ _____ ☐ Plant/Pollen: _____ ☐ Other: _____ Recent Surgery or hospitalization? _____ Immunizations Current? ☐ YES ☐ NO COVID Vaccine ☐ YES ☐ NO	LIST OF CURRENT MEDICATIONS ****Medicine:** _____ _____ _____ **Check all that apply, explain:** ☐ Asthma:_____ ☐ Diabetes: _____ ☐ Seizures: _____ ☐ Stomach Conditions: _____ ☐ Heart Conditions: _____ ☐ Other: _____

FOOD AND DIET INFORMATION

Significant Allergies (specify)

I have the following food allergies: _____

Please specify any diet restrictions: _____

Adult Bereavement History

Please include as many details as possible when answering the following questions. This will assist 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): _____
   Age(s) _____

2. Cause of death _____

3. How was the person (s) related you? _____

4. Were you present at the time of the death? ☐ Yes ☐ No

5. Where did this person die? ☐ Home? ☐ Hospital? ☐ Other _____

6. When did the death occur? (date) _____

7. Did you attend the funeral/memorial service? ☐ Yes ☐ No
   If yes, explain how you felt at the service:
   _____
   _____
   _____

8. Have you received any professional support to help with the grieving process? ☐ Yes ☐ No
   If yes, is support currently being provided? ☐ Yes ☐ No
   If counseling is no longer in progress how long was the period of support provided?
   _____
   _____

9. Have there been multiple deaths of loved ones?
   ☐ Yes ☐ No
   If yes, please describe the nature of death and the relationship to the person that died.
   _____
   _____
   _____

10. Have there been any other changes or stresses in your life?
    (i.e., divorce, remarriage, relocation, illness, etc.)
    _____
    _____
    _____

11. Any suicide attempts? If yes, please explain:
    _____
    _____

_____
Print name

_____ _____
Signature Date