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 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 _____

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

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?

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.

13. Have there been any other changes or stresses in your child's life?
(i.e., divorce, remarriage, relocation, illness, etc.)

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.

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

Print name of parent/guardian

Signature of parent/guardian

Date