Hospice of Ohio County's

DAY OF HOPE

A free program for youth ages 6 - 18

Date: Thursday, May 25th

Time: 10 AM to 3 PM

Location: Ohio County Park

Building #1 (At the top of the hill)

2300 KY Route 69, Hartford, KY 42347

Camp Activities

- Grief & Emotion Education
- Outdoor Experiences
- Guided Horse Riding (Equine Therapy)
- Remembrance Activities & Crafts

Purpose of the Camp

Day of Hope offers an opportunity for young people to commemorate and remember loved ones, and to better understand the emotions associated with loss and grief.

Who Should Attend?

Youth ages 6 - 18 who could benefit from grief education and emotional support.

To Register or for more information, contact:

Hospice of Ohio County
Phone: 270-298-9507
or Phone: 270-256-6099
email: lshaffer@ochcares.com

For Downloadable Application visit:
www.ochcares.com/hospice

The Cost is FREE.

Please call to register your child ASAP, (space is limited) and return registration packet by May 16th.

Participant Application Form

Hospice of OHIO COUNTY

Thursday, May 25th
10 AM - 3 PM

Ohio County Park
Building #1
2300 KY Route 69
Hartford, KY 42347

AGES 6 TO 18

Participant: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

School: _____ Grade in School: _____

Parent/Guardian: _____

Phone Numbers: _____ Email _____

Bereavement History

Please list child's most impactful or recent loss first, then others that may affect their grief experience.

NAME	Relationship And what child called them	Date of Death	Age of Death	Cause of Death Or any other info you'd like to share

Please note any helpful information regarding your child's current grief response:

_____

_____

_____

Since their death(s), has your child shown any of the following behaviors? (Check ALL that apply)

____ Problems in school
____ Withdrawing from family/friends
____ Seems angry a lot
____ Problems with appetite
____ Problems with sleeping
____ Nightmares
____ Lack of energy
____ Lack of interest in usual activities
____ Demands more attention
____ Other Behaviors?

_____

_____

Participant Health History Form

CHILD'S NAME: _____ _____ _____
First Middle Last

☐ **MALE** ☐ **FEMALE** **AGE:** _____ **DATE OF BIRTH:** _____/_____/_____

ADDRESS: _____

_____

Parent / Guardian # 1 Name and Relationship: _____

PHONE NUMBERS: Home: _____ Other: _____ Emergency: _____

Parent / Guardian # 2 Name and Relationship: _____

PHONE NUMBERS: Home: _____ Other: _____ Emergency: _____

CONTACT INFORMATION IN CASE OF EMERGENCY AND PARENTS/GUARDIAN UNAVAILABLE:

FIRST CONTACT'S NAME: _____

PHONE NUMBERS: Home: _____ Other: _____

SECOND CONTACT'S NAME: _____

PHONE NUMBERS: Home: _____ Other: _____

Child's Health History (check ALL that apply)

_____ DIABETES
_____ HEART DISEASE
_____ KIDNEY DISEASE
_____ ASTHMA
_____ EPILEPSY
_____ FAINTING
_____ CONVULSIONS/SEIZURES
_____ OTHER (Please List):
_____
_____
_____

_____ EMOTIONAL PROBLEMS
_____ EAR INFECTIONS
_____ HEARING IMPAIRMENT
_____ NOSE BLEEDS
_____ WEARS GLASSES
_____ WEARS CONTACT LENSES
_____ SPECIAL DIET NEEDS (List):
_____
_____
_____

_____ ALLERGIC TO BEE STINGS/ INSECT BITES?
_____ CHILD REQUIRES/CARRIES AN EPIPEN?

PLEASE LIST ALLERGIES:

___ ANIMALS:
_____
___ FOOD:
_____
___ GRASSES / TREES:
_____
___ MEDICATIONS / OTHER:
_____

Participant Health History Form continued...

Regarding any "checked" health conditions, please indicate any additional information that would be useful to the Camp Directors: _____

_____

_____

Are there other medical issues the Camp Directors should be aware of that are not listed? Please be specific:

_____

_____

_____

Please indicate any activities to be discouraged or restricted for your child:

_____

MEDICATIONS:

Please list all current medications prescribed for your child that will need to be administered while at Day of Hope, along with the purpose and dosage of each:

	NAME OF MEDICATION	PURPOSE	AMOUNT TO BE GIVEN
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Please list the date of the child's last Tetanus injection: _____

I hereby give permission to the Day of Hope nursing staff to administer prescriptions and over-the-counter medications brought from home, to administer First-Aid to my child if needed, and / or to access medical treatment for my child, including transportation, if I can not be reached in an emergency.

_____ _____

Signature of Parent/Guardian Date

Hospice of Ohio County

DAY OF HOPE INFORMED CONSTENT, AGREEMENT,
RELEASE OF LIABILITY AND PHOTO PERMISSION/RELEASE

Informed Consent

I hereby give permission for my child, _____ to attend Day of Hope on May 25, 2023 and I understand that Day of Hope's goal is to help facilitate the bereavement process of my child and provide support for him/her in expressing feelings of grief.

_____ Parent/Guardian Initials

Waiver and Release of Liability

As parent or guardian of my child, I agree that I will not hold Day of Hope, (a program of Hospice of Ohio County), its employees, officers, directors, volunteers, agents and contractors liable for any personal injury, property damage, loss of insurance. I agree to release and hold harmless Hospice of Ohio County, its employees, officers, directors, volunteers, agents and contractors from all liability incurred as a result of my child's participation in camp, and that these terms serve as a release for myself and members of my family.

_____ Parent/Guardian Initials

PHOTO AND STORY RELEASE AUTHORIZATION

Regarding my/ my child's participation in Day of Hope, I hereby grant Hospice of Ohio County permission to use any photos / videos that may be taken of me / my child, or in which I / my child may be included with others. I also grant permission for the use of my / my child's name and / or quotations of my / my child's remarks, in whole or in part, for public information and promotion purposes.

I understand that the photographic images and written information may be used for the purpose of promoting Hospice of Ohio County. Promotions may be in the form of all media, print and / or broadcast, website content, or public presentations.

_____

Parent / Guardian Name (please print)

_____ _____

Parent / Guardian Signature **Date**

OHIO COUNTY EQUESTRIAN, INC.

LIABILITY RELEASE FORM

By signing this agreement, I understand that I release and forever discharge Ohio County Equestrian, Inc., John and Rhonda Leach, their heirs, volunteers, livestock, and anyone involved with the corporation from any and all liability or responsibility for injury, loss, or damage the person named below may suffer, from any cause whatsoever, whether such injury, loss, or damage may be occasioned by the negligence of Ohio County Equestrian, Inc., John and Rhonda Leach, their heirs, volunteers, or anyone involved with said corporation.

Rider's printed name _____

Rider's signature (if over age 18) _____ Date _____

Parent/Guardian printed name _____

Parent/Guardian signature _____ Date _____

Riders over age 18 must sign their own name. An "X" must be witnessed by someone over 18 years of age and sign below.

Witness printed name _____

Witness _____ Date _____

MEDIA RELEASE CLAUSE**

I give my permission for Ohio County Equestrian, Inc. to use my likeness, name, and/or voice on television, radio, pictures, etc., to promote this program by any of the above media as deemed appropriate by Ohio County Equestrian, Inc.

Authorized printed name _____

Authorized Signature _____ Date _____

** You do not have to sign the media release to ride, but we would truly appreciate it if you would.