



Time for Teens, Inc.
P.O. Box 552
Southampton, NY 11969

Dear Parent/Guardian:

Thank you for your interest in sending your child to the Time for Teens Bereavement Retreat. We promise to make this a memorable experience for your child. Enclosed is an information packet that includes all the necessary information to enroll your child in our retreat.

After you have completed and returned the entire package, a grief counselor will contact you to talk with you firsthand about your child. The counselor can give you an overview of what you can expect from the retreat. If, for some reason, Time for Teens Camp is unable to meet your child's needs, we will call to discuss that with you.

Parents/guardians are expected to provide transportation for dropping off and picking up their children daily, at identified pick up/drop off areas. This specified information will be provided to you two weeks prior to the retreat dates.

Retreat is limited to approximately 15 campers, so please return your application promptly. Mail application to: Time for Teens, Inc. PO Box 552, Southampton, NY 11969. There is a nominal fee of \$25 per child for this service, donations are appreciated.

We look forward to making this a rewarding, fun and healing time for your child. Please address any questions you may have to Laraine Gordon at 631-338-7258 or e-mail: Laraine@LaraineGordon.com.

Sincerely,

A handwritten signature in black ink, appearing to read "Laraine Gordon".

Laraine Gordon
Executive Director, Time for Teens Inc.

TIME FOR TEENS APPLICATION DEADLINE July 1st, 2011

Mail to: Time for Teens, PO Box 552, Southampton, NY 11969

Information as to why your child is coming to camp.

1. Name of deceased: _____ Relationship to child: _____
2. When did the death occur? Briefly describe the circumstances of the death (i.e., cancer, heart attack, motor vehicle accident).
3. What is happening or has happened to indicate your child is still grieving the loss?
4. Have there been multiple deaths in the family? If yes, please include the name and relationship to the child and circumstance of the loss:
5. In addition to deaths, have there been any other important changes in your child's life? Examples: moved to new school, new city, loss through divorce.
6. Please describe your child's personality (i.e., shy, outgoing) and activities your child enjoys.
7. Please let us know how you heard about Time for Teens.

CAMP NOTES: _____

Many of the activities at camp are out-of-doors. Please provide sun screen lotion if your child requires such protection. Also please provide a towel and a bathing suit.

All medications as described on the health form must be given to the Camp nurse at Camp check in time. All medications must be in original prescription containers and be clearly marked with the above information. Please provide only the amount of medication needed for the week, as we are required to count each tablet. Please be sure to specify if the medication needs to be refrigerated. If your child is currently taking Ritalin during the week, please have them take it at this particular time as well.

Please attach a recent photo of your child so we may put a name to the face.

TIME FOR TEENS

Informed Consent, Release and Indemnification Agreement

I, _____ hereby give permission for my Child(ren) to attend Time for Teens Bereavement Retreat August 1st – August 4th, 2011. This retreat will be held at a private estate in Southampton, NY. I understand the goal of Time for Teens is to help facilitate my child's bereavement process and provide support for him or her in expressing feelings of grief. I give permission to the Time for Teens staff to share the information contained in this packet with the volunteers and staff who will be working with my child.

1. Authorization is hereby granted to release and to obtain from appropriate agencies, school personnel, health and mental health providers, such information as may assist Time for Teens personnel in providing support for my child.
2. I give permission for my child to be photographed and/or videotaped during Time for Teens. I agree that these photographs/videos are and remain the property of Time for Teens and that these images may now, or in the future, be used by Time for Teens for promotional and/or educational purposes in any medium, including but not limited to, print materials, in digital or electronic form, and/or on the Time for Teens website.
3. In consideration of the above named child being granted permission by Time for Teens to attend the Time for Teens Program, I, for myself and on behalf of my child, release and discharge Time for Teens, its agents, employees, volunteers, officers and directors from all claims, demands, actions and judgments which I or my child has had, now has, or may in the future have against Time for Teens for any personal, physical or emotional injury, known or unknown, and any injury to property during my child's attendance at Time for Teens Bereavement Retreat in 2010, whether the injury is caused by negligence or any other fault.
4. INDEMNIFICATION AGREEMENT: In consideration of the above named child being granted permission by Time for Teens to attend the Time for Teens Program, I agree to indemnify and hold harmless, Time for Teens against any and all claims, demands, actions and judgments whatsoever, in law and equity, which my child has had, now has or may in the future have against Time for Teens, for any personal, physical or emotional injury to property during my child's attendance at Time for Teens, including, but not limited to, injury caused by, or arising out of negligence conduct by Time for Teens' agents, employees, volunteers, officers or directors.

I, the undersigned, have read this release and understand all of its terms.

Date: _____

Signed: _____
Parent/Guardian



TIME FOR TEENS APPLICATION
August 1, 2, 3 & 4 2011

Child's Name _____

Mailing Address _____

Age _____ Date of Birth _____ Male Female

Upcoming School Year _____ School Attending _____ Grade _____

Mother/Guardian _____

Address (if different) _____

Contact Information - Home Phone _____ Work _____ Cell _____

E-mail _____

Father/Guardian _____

Address (if different) _____

Contact Information - Home Phone _____ Work _____ Cell _____

E-mail _____

RECREATIONAL INTERESTS

____ Swimming _____ Arts & Crafts _____ Soccer _____ Basketball _____ Kickball

____ Volley Ball _____ Board Games _____ Drama _____ Story Telling _____ Nature Hikes

____ Other (please explain) _____

HEALTH HISTORY

Does this child have any health problems? _____

Any dietary restrictions? _____ Allergies? _____

Are all of your child's immunizations up-to-date? _____

If there are medications that may need to be administered to your child during camp, please fill out the Medication Profile below and bring to Camp in original packaging.

MEDICATION PROFILE

Name of medication to be administered: _____ Dosage: _____

Time to be administered: _____ Physician's Name: _____ Phone # _____

I give permission to the Time For Teens Staff to administer prescriptions named above, if applicable, and/or first aid to my child.

IN CASE OF EMERGENCY, CONTACT _____ Phone # _____

Signature _____

Date _____

T-SHIRT SIZE Children _____ S _____ M _____ L

Adult _____ S _____ M _____ L

Health History and Examination Form for Children, Youth and Adults Attending Camps

FM 08N

Suggested for resident camp use.

Developed and approved by
American Camping Association®
American Academy of Pediatrics
Expires 12/31/03

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or by adults

Dates of Camp Attendance _____

Mail this form to the address below by _____ (date)

themselves. Update required annually. Health exam (back page) must be completed by approved licensed medical personnel at least every two years.

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street address City State Zip

Social security number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home address _____
(if different from above) Street address City State Zip

Business address _____ Phone _____
Street address City State Zip

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street address City State Zip

Business address _____ Phone _____

If not available in an emergency, notify:

Name _____

Relationship _____ Phone _____

Address _____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

► **Photocopy of front and back of health insurance card must be attached to this form.**

Important — These boxes must be complete for attendance*

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment,

Signature of parent/guardian or adult camper/staffer _____

Printed Name _____ Date _____

referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer _____ Date _____

*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Year

Cabin or Group

Name

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the

completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known.

Describe reaction and management of the reaction.

Medication allergies (list)

_____	_____
_____	_____
_____	_____

Food allergies (list)

_____	_____
_____	_____
_____	_____

Other allergies (list) — include insect stings, hay fever, asthma, animal dander, etc.

_____	_____
_____	_____
_____	_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original

packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____	Dosage _____	Specific times taken each day _____
Reason for taking _____		
Med #2 _____	Dosage _____	Specific times taken each day _____
Reason for taking _____		
Med #3 _____	Dosage _____	Specific times taken each day _____
Reason for taking _____		

Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer: _____

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

- | | | |
|---|---|--|
| <input type="checkbox"/> Does not eat red meat | <input type="checkbox"/> Does not eat pork | <input type="checkbox"/> Does not eat eggs |
| <input type="checkbox"/> Does not eat poultry | <input type="checkbox"/> Does not eat seafood | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> Other (describe) _____ | | |

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition? ...	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise? ...	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

Which of the following has the participant had?	Please give all dates of immunization for:								
	Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	DTP		_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken pox	TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	Tetanus		_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio		_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR		_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles		_____	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps		_____	_____	_____	_____	_____	_____	_____
	or Rubella		_____	_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B		_____	_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B		_____	_____	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)		_____	_____	_____	_____	_____	_____	_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (ACA accreditation requirements specify exams within 24 months of camp attendance. Individual camps may require annual exams. A new exam is not necessarily required for camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

Recommendations and Restrictions at Camp

Treatment to be continued at camp

Medications to be administered at camp (name, dosage, frequency)

Any medically-prescribed meal plan or dietary restrictions

Known allergies

Description of any limitation or restriction on camp activities

Additional information for health care staff at the camp

Signature of Licensed Medical Personnel _____
Printed _____ Title _____
Address _____
Phone _____ Date _____

For camp use only

Screening Record
Date screened _____ Time _____ am
pm
Meds received _____

Updates/additions to health history noted Yes No None required
Current health needs identified _____

Observational notes _____

Screened by _____