



## PRESCHOOL-AGE SUPPORT GROUP Enrollment Form

It is our mission to offer support to grieving families in a manner that is most beneficial for you. Because of this desire, we are asking for you to sit with your child and complete this enrollment form as thoroughly as possible. Thank you.

**Child's Name** \_\_\_\_\_ **Sex**    M    F

**Nickname, if any** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Age at the time of the loved one's death** \_\_\_\_\_

**Name of Child's School** \_\_\_\_\_ **Grade in School** \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

How are you related to this child? \_\_\_\_\_

How are you related to the deceased? \_\_\_\_\_

Will you be attending these groups?    Yes    No

Parent/Guardian's Name \_\_\_\_\_

How are you related to this child? \_\_\_\_\_

How are you related to the deceased? \_\_\_\_\_

Will you be attending these groups?    Yes    No

Parent/Guardian's Name \_\_\_\_\_

How are you related to this child? \_\_\_\_\_

How are you related to the deceased? \_\_\_\_\_

Will you be attending these groups?    Yes    No

Parent/Guardian's Name \_\_\_\_\_

How are you related to this child? \_\_\_\_\_

How are you related to the deceased? \_\_\_\_\_

Will you be attending these groups?    Yes    No

**Primary Parent/Guardian Address** \_\_\_\_\_

**City/State/Zip** \_\_\_\_\_

**Do you live within St. Louis City Limits?**    YES    NO    **If not, in what county do you live?**

**Phone: (Home)** \_\_\_\_\_ **(Work)** \_\_\_\_\_

**(Cell)** \_\_\_\_\_

**E-Mail address:** \_\_\_\_\_

**Parent/Guardian's Place of Employment:**

**Name of person who is completing this form for the child:** \_\_\_\_\_

Is this child's home address the same as the primary parent/guardian?    Yes    No

If not, please provide the child's home address:

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: (Home) \_\_\_\_\_

Please describe your child's personality/hobbies/struggles/talents:

Names of brothers and sisters:	D.O.B	Age	Sex	Attending Support Groups?	
_____	_____	_____	_____	YES	NO
_____	_____	_____	_____	YES	NO
_____	_____	_____	_____	YES	NO
_____	_____	_____	_____	YES	NO
_____	_____	_____	_____	YES	NO

**Background information on the deceased individual(s).**

Full Name \_\_\_\_\_

How is the deceased person related to this Child? She/He is her/his \_\_\_\_\_.

Date of Birth \_\_\_\_\_ Date of Death \_\_\_\_\_

Former Place of Employment (if applicable):  
\_\_\_\_\_

Nature of the Death: please check all that are applicable

- |  |                                   |                                       |                                 |
|--|-----------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Short illness | <input type="checkbox"/> Accident | <input type="checkbox"/> Suicide      | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Long illness  | <input type="checkbox"/> Murder   | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Other  |

Please give a brief account of the death.

Was an accurate, honest explanation of the death provided for your child?

Yes                      No

If not, what explanation was given to your child?

Is this the first experience with death for your child?                      Yes                      No

If no, please explain briefly all losses by death:

What other losses has your child experienced? For ex. abandonment, divorce, moving, abuse etc.

Who told your child about the loved one's death and how was it done? What was your child's reaction?

Please briefly state your religious affiliation, if any, and state what religious or spiritual beliefs were used to explain this death to your child.

Did your child get to say goodbye?                      Yes                      No  
If yes, in what way?

—  
Did your child attend the funeral?                      Yes                      No

Did your child plan or participate in the funeral/memorial service/shiva?  
                    Yes                      No  
If yes, in what way?

Did your child view the deceased?                      Yes                      No  
If yes, what was your child's reaction and what was your response to your child?

Has your child ever lost a pet through death?                      Yes                      No  
If yes, what was the child's reaction and how was the death handled by the child and family members?

Have you shown any of the following behaviors since your experience with this death?

Please fill in a number between 0 & 10 that equals how often the behavior occurs.

0 = never, 5 = sometimes, & 10 = very frequently

- |     |   |     |   |
|-----|---|-----|---|
| 1.  | afraid of the dark                                  | 16. | over eating                             |
| 2.  | afraid to go to bed                                 | 17. | loss of appetite                        |
| 3.  | afraid of hospitals, physicians or<br>their offices | 18. | bed wetting                             |
| 4.  | repeated illnesses                                  | 19. | cruelty to animals                      |
| 5.  | attachment to parent or guardian                    | 20. | withdrawal from family                  |
| 6.  | lowered school grades                               | 21. | withdrawal from friends                 |
| 7.  | improved school grades                              | 22. | obsession with death                    |
| 8.  | intense anger                                       | 23. | change in sexual activity               |
| 9.  | nightmares  | 24. | use of drugs                            |
| 10. | overprotective behavior towards<br>others           | 25. | use of alcohol                          |
| 11. | physical fighting                                   | 26. | use of cigarettes                       |
| 12. | increased arguing                                   | 27. | difficulty concentrating                |
| 13. | hurtful behavior to self                            | 28. | over sleeping                           |
| 14. | hurtful behavior to others                          | 29. | difficulty sleeping                     |
| 15. | destruction of property                             | 30. | participation in risk-taking activities |

Please add details about any of the behaviors listed above, especially, hurtful to self or others, destruction of property, cruelty to animals, use of drugs, alcohol or cigarettes, & fighting.

Any recent changes of the members of the household other than the deceased? (separation, divorce, additional members, etc.)

Any recent changes in environment? (move, new school, new job, caregivers, etc.)

How have the responsibilities at home changed for your child since the death occurred?

Is there any additional information we should know?

What do you hope for your child to gain from attending the support groups?

Has your child ever received professional counseling?            Yes            No  
When and with whom? May we contact the professional therapist to discuss your child's needs?            Yes            No

Does your child take any medications for depression, anxiety, Bipolar Disease, Attention Deficit  
Hyperactivity Disorder (A.D.H.D.) or A.D.D.?            Yes            No  
If yes, please list the medications below:

Please share any social, emotional, physical or psychological struggles/challenges/limitations that your child is experiencing now or in the past.

Does your child have any allergies?            Yes            No  
If yes, please list below:

Is your child allergic or fearful of dogs?            Yes            No

May your child have snacks?            Yes            No

Does your child have any dietary restrictions?            Yes            No  
If yes, please list below:

May your child participate in outside play? Yes No

Is your child fully potty trained? Yes No

If not, please explain:

\*\*\* If your child is not potty trained then you will be responsible for diapering. Please remember to bring the necessary supplies.

*To raise money for our programs, Annie's Hope applies for grant money from foundations and corporations. To do so, we need answers to the following questions. Please remember your answers are strictly confidential and optional.*

Does your child qualify for a free or reduced school lunch program? YES NO I DON'T KNOW

Do you receive ADC, SSI (Supplemental Security Income) or Food Stamps? YES NO I DON'T KNOW

Do you belong to an organized religion? YES NO

If so, please name the religion: \_\_\_\_\_

Please check your child's race/ethnic background (check as many as needed):

African-American

Caucasian

Hispanic

Asian

Native American Indian

Other \_\_\_\_\_

Does your son/daughter have insurance coverage? YES NO I DON'T KNOW

If yes, is it Medicaid? YES NO I DON'T KNOW

Does it include mental health coverage? YES NO I DON'T KNOW

**Signature of Your Child!!** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Director/Facilitator** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE MAIL OR FAX THE COMPLETED FORMS BACK TO:**

Annie's Hope  
1333 W. Lockwood, Ste. 104  
Glendale, MO 63122

314-918-1438 (Fax)  
  
forms.annieshope@gmail.com

For any questions or concerns, please contact our office at 314-965-5015.



**PHOTOGRAPHIC RELEASE**  
**Child**

In an effort to increase awareness in the community about Annie's Hope and to raise money to support our programs and services, we ask that you allow Annie's Hope staff or volunteers to take pictures of your child. The pictures may be used in our newsletter, on our web site, in our brochure, in slideshows, or in any other way that helps us to let the public know about Annie's Hope.

I, \_\_\_\_\_, hereby  
parent/guardian

authorize *Annie's Hope* to take photographs, film, audiotapes, and  
videotapes of my child, \_\_\_\_\_, and  
child's name

to use them in newspapers, publications, and presentations.

*Annie's Hope* may use these such items and information in whatever way  
the organization considers proper and desirable.

Date: \_\_\_\_\_

Signature of parent or legal guardian:

\_\_\_\_\_

Phone number: \_\_\_\_\_

REVISED 8-10-06