



SCHOOL-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 _____ **Age** _____
Name of Child's School _____ **Current Grade in School** _____

Parent(s)/Guardian(s)/Adults attending support groups with the child?

Name: _____ Relationship: _____
 Name: _____ Relationship: _____
 Name: _____ Relationship: _____

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

****Please update any contact information that has changed since attending last support group program**

Parent/Guardian's Name _____ Parent/Guardian's Name _____
 How are you related to this child? _____ How are you related to this child? _____
 How are you related to the deceased? _____ How are you related to the deceased? _____

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 _____ Home Phone _____

Has your child shown any of the following behaviors since his/her 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 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 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 in environment or household?

A move	Yes	No	Separation/Divorce/Remarriages	Yes	No
New school	Yes	No	New caregivers	Yes	No
New job	Yes	No	New responsibilities at home	Yes	No

Please add details to any changes marked “yes”.

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 have any conditions that require regular medications? Yes No
If yes, please complete the information below.

Medication	Reason for Medication
_____	_____
_____	_____
_____	_____

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

Has your child experienced the death of anyone else significant since attending the last Annie's Hope program? Yes No If yes, please complete the following:

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 apply.

Short Illness	Accident	Suicide	Cancer
Long Illness	Murder	Heart Attack	Other

Please give a brief account of the death.

Was an accurate, honest explanation of the death given to your child? Yes No
If not, what explanation was given to him/her?

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

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, EMAIL, 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