

For Office Use
 Received: _____
 Permission: _____
 Health: _____
 Photo Release: _____
 Trans. Waiver: _____
 Accepted: _____
 Supply Needs: Y or N
 Reminder: _____



Teen Retreat “Journeys” 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 you to complete this enrollment form as thoroughly as possible. Your answers are confidential. Thank you.

Your Name _____ **Sex** M or F

Nickname, if any _____

Date of Birth _____ **Age** _____ **Age at the time of the loved one’s death** _____

Grade in School _____ **Name of Your School** _____

Your Address _____

City/State/Zip _____

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

Your Phone: (Home) _____ **(Work)** _____

(Cell) _____ **Your E-Mail address:** _____

Your Place of Employment: _____

Parent/Guardian(s) Name	His/Her Relationship to you	His/Her Relationship to the deceased
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent(s)/Guardian(s) Cell _____

Parent(s)/Guardian(s) E-Mail address _____

Parent/Guardian’s Place of Employment _____

Is Your Address the Same as Your Parent(s)/Guardian(s)? Yes No

If Not, What is Their Address?

City/State/Zip _____

Phone: (Home) _____ **(Work)** _____

Please describe your personality/hobbies/talents:

Names of brothers and sisters:	D.O.B	Age	Sex	Attending Teen Retreat?
_____	_____	_____	_____	YES or NO
_____	_____	_____	_____	YES or NO
_____	_____	_____	_____	YES or NO
_____	_____	_____	_____	YES or NO
_____	_____	_____	_____	YES or NO

Background information on the deceased individual(s).

Full Name _____

How is the deceased related to you? He/she is my: _____

Your relationship to him/her: _____

Date of Birth _____ Date of Death _____

Former Place of Employment (if applicable):

Nature of the Death: please check all that are applicable

- Short illness Accident Suicide Cancer
 Long illness Murder Heart Attack Other

Please tell us the story of the death.

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

Yes No

If not, what explanation was given to your teen?

Is this the first experience with death for you? Yes No

If no, please briefly explain all losses by death:

What other losses have you experienced? For example, abandonment, divorce, moving, break up, etc.

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

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

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

Did you attend in the funeral? Yes No

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

Did you view the deceased? Yes No
If yes, what was your reaction?

Have you ever lost a pet through death? Yes No
If yes, what was your reaction and how was the death handled by other family members?

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

Please circle a number between 0 & 10 that equals how often the behavior occurs.
0 = never, 5 = sometimes, & 10 = very frequently

1.	afraid of the dark	0	1	2	3	4	5	6	7	8	9	10
2.	afraid to go to bed	0	1	2	3	4	5	6	7	8	9	10
3.	afraid of hospitals, physicians or their offices	0	1	2	3	4	5	6	7	8	9	10
4.	repeated illnesses	0	1	2	3	4	5	6	7	8	9	10
5.	attachment to parent or guardian	0	1	2	3	4	5	6	7	8	9	10
6.	lowered school grades	0	1	2	3	4	5	6	7	8	9	10
7.	improved school grades	0	1	2	3	4	5	6	7	8	9	10
8.	intense anger	0	1	2	3	4	5	6	7	8	9	10
9.	nightmares	0	1	2	3	4	5	6	7	8	9	10
10.	overprotective behavior towards others	0	1	2	3	4	5	6	7	8	9	10
11.	physical fighting	0	1	2	3	4	5	6	7	8	9	10
12.	increased arguing	0	1	2	3	4	5	6	7	8	9	10
13.	hurtful behavior to self	0	1	2	3	4	5	6	7	8	9	10
14.	hurtful behavior to others	0	1	2	3	4	5	6	7	8	9	10
15.	destruction of property	0	1	2	3	4	5	6	7	8	9	10
16.	over eating	0	1	2	3	4	5	6	7	8	9	10
17.	loss of appetite	0	1	2	3	4	5	6	7	8	9	10
18.	bed wetting	0	1	2	3	4	5	6	7	8	9	10
19.	cruelty to animals	0	1	2	3	4	5	6	7	8	9	10
20.	withdrawal from family	0	1	2	3	4	5	6	7	8	9	10
21.	withdrawal from friends	0	1	2	3	4	5	6	7	8	9	10
22.	obsession with death	0	1	2	3	4	5	6	7	8	9	10
23.	change in sexual activity	0	1	2	3	4	5	6	7	8	9	10
24.	use of drugs	0	1	2	3	4	5	6	7	8	9	10
25.	use of alcohol	0	1	2	3	4	5	6	7	8	9	10
26.	use of cigarettes	0	1	2	3	4	5	6	7	8	9	10
27.	difficulty concentrating	0	1	2	3	4	5	6	7	8	9	10
28.	over sleeping	0	1	2	3	4	5	6	7	8	9	10
29.	difficulty sleeping	0	1	2	3	4	5	6	7	8	9	10
30.	participation in risk-taking activities	0	1	2	3	4	5	6	7	8	9	10

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 you since the death occurred?

Is there any additional information we should know?

What do you hope to gain from attending the Teen Retreat?

Have you ever received professional counseling? Yes No
When and with whom?

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

Can you participate in outside activities? Yes No

Can you have snacks? Yes No

Are you afraid of dogs? Yes No

Revised 09-24-09

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.

Do you qualify for a free or reduced school lunch program? YES____ NO____ I DON'T KNOW ____

Does your family receive ADC, 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 race/ethnic background (check as many as needed):
African-American ____ Caucasian ____ Hispanic ____ Asian ____
Native American Indian ____ Other _____

Do you 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 ____

TEENAGERS SIGNATURE!! _____ **Date** _____
Signature of Parent/Guardian _____ **Date** _____
Signature of Director/Facilitator _____ **Date** _____

P.S. Please remember to include your parent/guardian's section.

PLEASE MAIL OR FAX THE COMPLETED FORMS BACK TO:

Annie's Hope 314-918-1438 (Fax)
1333 W. Lockwood, Ste. 104
Glendale, MO 63122 annieshope.ali@gmail.com

For any questions or concerns, please contact Ali Johnson, Program Director, at 314-965-5015 (Office) or Ali's cell phone at 217-419-2338.

STOP!

These pages are for your parent/guardian to complete

Teenager's name: _____

Who is completing this form for the teen? _____

Please describe your teen's personality/hobbies/talents: _____

In your opinion, has your teenager shown any of the following behaviors since his/her experience with this death?

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

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

- | | | | | | | | | | | | | |
|-----|--------------------------------------------------|---|---|---|---|---|---|---|---|---|---|----|
| 1. | afraid of the dark | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. | afraid to go to bed | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. | afraid of hospitals, physicians or their offices | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4. | repeated illnesses | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 5. | attachment to parent or guardian | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 6. | lowered school grades | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 7. | improved school grades | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 8. | intense anger | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 9. | nightmares | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 10. | overprotective behavior towards others | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11. | physical fighting | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 12. | increased arguing | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 13. | hurtful behavior to self | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 14. | hurtful behavior to others | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 15. | destruction of property | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 16. | over eating | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 17. | loss of appetite | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 18. | bed wetting | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 19. | cruelty to animals | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 20. | withdrawal from family | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 21. | withdrawal from friends | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 22. | obsession with death | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 23. | change in sexual activity | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 24. | use of drugs | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 25. | use of alcohol | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 26. | use of cigarettes | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 27. | difficulty concentrating | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 28. | over sleeping | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 29. | difficulty sleeping | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 30. | participation in risk-taking activities | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

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, changes in sexual activity, & fighting.

If your teenager has a professional counselor/therapist, may we contact him/her to discuss your teen's needs? YES _____ NO _____ Name & Phone Number: _____

Teen Retreat 2009 Health Examination Form

Teen's Name: _____

Birthdate: ____/____/____ Age: _____

Parent/Guardian Name: _____

Telephone: Home: _____ Work: _____

Cell Phone: _____ Pager: _____

Home Address: _____

In an Emergency, notify (other than parents):

(Please list persons who will be available during the Teen Retreat Weekend and their contact number)

Doctor's Name: _____ **Telephone:** _____

Health History (please **circle** if the camper has experienced this)

Diabetes	Fainting	Convulsions/Seizures	Homesickness
Asthma/Wheezing	Stomach Upset	Athlete's Foot	Tubes in ears
Heart Troubles	Constipation	Sleep walking	Poison Ivy/ Oak
Bed wetting	Seasonal Allergies		

Has your teen ever needed an inhaler or nebulizer for wheezing or asthma? Yes or No

Operations, serious illness: _____

Does your teen have any of the following (please circle yes or no):

Drug allergies: Yes / No If yes, please list: _____

Food allergies: Yes / No If yes, please list: _____

Allergic reactions: Bee Stings: Yes / No Poison Ivy/Oak: Yes / No Mosquito bites: Yes / No

If yes, please describe: _____

Additional information

Is this the first time your teen has stayed overnight without your presence? Yes or No

Any specific activities to be restricted? Yes / No If yes, please explain: _____

Does the teen know how to swim? Yes / No If so, please circle: poor average very good

Are the teen's immunizations up-to-date: please circle YES / NO

Date of Teen's last Tetanus shot: _____

Does he/she have any condition requiring regular medication? Yes or No (please circle)

If yes, please complete the information below. "X" the time of day the med is given.

<u>Medication</u>	<u>Dose</u>	<u>B-fast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Bedtime</u>	<u>Other</u>	<u>Reason for Med</u>
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Any additional instructions: _____

Who would you like to store & dispense your teen's medications?
Please check the chosen person. _____ my teenager _____ Annie's Hope staff

Any specific equipment needed? (i.e., braces, glasses, contacts, retainers, cast): _____

Is the teen afraid of dogs?: _____

Does the teen have any special diet needs? _____ If so, what? _____

Please **circle** any of the following over-the-counter medications that the Retreat Nurse may give to the teen as he/she deems necessary:

Benadryl Tylenol Ibuprofen Saline Eye Rinse Calamine Lotion Tums

NOTE: Please notify the Retreat Leader if this teen is exposed to any communicable disease in the three weeks prior to camp attendance (Chicken Pox, Mumps, Measles, etc.)

Insurance Coverage: _____

Policy ID/Medicaid Number: _____

In the case of medical emergency, I understand every effort will be made to contact the parents or guardian of the teen. In the event I cannot be reached, I hereby give permission to the physician selected by the Retreat Leader to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my teen as named above:

*****Parent/Guardian Signature:** _____

Date: _____

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Annie's Hope & Teen Retreat

PHOTOGRAPHIC RELEASE

I, _____, hereby authorize *Annie's Hope* to take
Name of Parent/Guardian
photographs, film, audiotapes, and videotapes of my child/teen, _____,
Name of Teen

and 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/Guardian: _____

Phone Number: _____

TRANSPORTATION WAIVER

I, _____ hereby grant permission for
Name of Parent/Guardian
Annie's Hope to transport my teen _____ to and from
Name of Teen

the Teen Retreat held at Sunnyhill Adventures in Dittmer, MO. I release *Annie's Hope* and

Sunnyhill Adventures from responsibility and liability if any injuries are incurred in connection

with being transported to and from the Teen Retreat.

Date: _____

Signature of Parent/Guardian: _____

SUNNYHILL ADVENTURES
A PROGRAM OF SUNNYHILL INC.
CONSENT FOR SERVICES

In consideration of admission of _____ (Participant) for the various programs conducted by Sunnyhill Adventures, a program of Sunnyhill Inc., I/we give the unqualified right and permission to:

1. Participate in camp activities on and off site including but not limited to: Swimming, canoeing, boating, rock climbing, tower climbing, archery, caving, programs and activities off camp and in the community, riding in vehicles, and all camp activities, etc.

2. I hereby indemnify said council, its' agents and employees, and agree to hold it and them harmless from any and all liability arising out of any injury, or accident that might happen to the applicant, and from any damage the applicant might cause to any person(s) or property while in the care of Sunnyhill Inc., its' agents and employees. I further understand that the applicant can be excluded at any time during the program by the director if it is judged that the applicant has hampered the safety, welfare, or enjoyment of self or other in the program.

I have read or have been read the foregoing, which I understand to be consent for services, release and indemnification, and I understand this fully.

In witness whereof, I have executed this consent and indemnification.

(Applicant's signature)

(Signature of parent or guardian)

(Witness)

(Date)