



## 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 or 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? \_\_\_\_\_

Are you attending support groups? Yes No

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

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

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

Are you attending support groups? Yes No

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

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

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

Are you attending support groups? Yes No

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

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

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

Are you attending support groups? Yes No

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

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

**Do you live within St. Louis City Limits? YES or 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: \_\_\_\_\_

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Names of brothers and sisters:	D.O.B	Age	Sex	Attending Support Groups?
_____	_____	_____	_____	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 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?

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

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

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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?

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Did your child view the deceased?  Yes  No

If yes, what was your child's reaction and what was your response to your child?

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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?

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Has your child shown any of the following behaviors since her/his 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.	clinging to parent or guardian	0	1	2	3	4	5	6	7	8	9	10
6.	changes in school work	0	1	2	3	4	5	6	7	8	9	10
7.	intense anger at self or others	0	1	2	3	4	5	6	7	8	9	10
8.	nightmares	0	1	2	3	4	5	6	7	8	9	10
9.	tantrums	0	1	2	3	4	5	6	7	8	9	10
10.	fighting	0	1	2	3	4	5	6	7	8	9	10
11.	hurtful behavior to self	0	1	2	3	4	5	6	7	8	9	10
12.	hurtful behavior to others	0	1	2	3	4	5	6	7	8	9	10
13.	destruction of property	0	1	2	3	4	5	6	7	8	9	10
14.	over or under eating	0	1	2	3	4	5	6	7	8	9	10
15.	bed wetting	0	1	2	3	4	5	6	7	8	9	10
16.	cruelty to animals	0	1	2	3	4	5	6	7	8	9	10
17.	withdrawal from family or friends	0	1	2	3	4	5	6	7	8	9	10
18.	obsession with death	0	1	2	3	4	5	6	7	8	9	10
19.	experimentation with sex	0	1	2	3	4	5	6	7	8	9	10
20.	use of drugs, alcohol or cigarettes	0	1	2	3	4	5	6	7	8	9	10
21.	difficulty concentrating	0	1	2	3	4	5	6	7	8	9	10
22.	oversleeping	0	1	2	3	4	5	6	7	8	9	10
23.	difficulty sleeping	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.

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

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

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

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Is there any additional information we should know?

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

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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

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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:

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

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Does your child have any allergies? Yes No

If yes, please list below:

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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:

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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 OR FAX THE COMPLETED FORMS BACK TO:**

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

314-918-1438 (Fax).  
or 314-965-8466 (Fax)  
annieshope.ali@gmail.com

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



**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