MERCYHEALTH

June 5, 2024

Dear Trails Grief Camp Families,

Since 1997, St. Rita's Hospice has facilitated "Trails" a grief camp for school aged children.

"Trails" will be held on Wednesday, August 7, 2024 or on Wednesday, August 14, 2024, from 9:00-3:30 PM, at The Equestrian Therapy Program located at 22532 Bowsher Rd., Cridersville, OH 45806.

PLEASE NOTE: Kids attending the 7th grade through high school during the school year (2023-2024) will be attending on Wednesday, August 7, 2024.

Kids attending the first grade through 6th grade during the school year (2023-2024) will be attending on Wednesday, August 14, 2024.

Registration is required. No one is denied due to hardship. However, we ask for a donation of $30 for one camper, $45 for two campers and $60 for three or more campers attending camp for the same deceased member.

To find out more about "TRAILS" email Herb Wilker at hiwilker@mercy.com or by phone at 419-226-9556.

To register, please complete both: the registration, "Liability Waiver/Insurance Information" forms and return it immediately in the enclosed envelope, by email or fax to 419-996-5234.

Sincerely,

Herb Wilker BCC LSW Vanessa Mattevi LSW David Harper LISW ACHP-SW
St. Rita's Hospice Bereavement Coordinator and Social Workers

TRAILS REGISTRATION

CAMP YEAR: 2024

PARENT/ADULT NAME:_____

ADDRESS:_____

CITY:_____ZIP:_____

TELEPHONE: HOME_____CELL:_____

NAME AND PHONE NUMBER OF WHO WILL BE TRANSPORTING YOUR CHILD TO AND FROM CAMP:

_____

CHILDREN'S NAMES, **GRADE LEVEL COMPLETED 2023-2024 SCHOOL YEAR**, DATE OF BIRTH

_____

_____

_____

NAME OF DECEASED:_____

RELATIONSHIP TO CHILDREN:_____

DATE OF DEATH:_____

DESCRIBE CIRCUMSTANCES OF DEATH:_____

_____

DESCRIBE THE ADJUSTMENT OF THE CHILDREN:_____

_____.

Liability Waiver/Insurance Information

To whom it may concern

Regarding Participant _____ Age _____

I, the undersigned, being the parent, legal next of kin or legal guardian hereby accept the responsibility for any injury he/she may receive at the TRAILS Grief Camp and authorize any necessary medical treatment and related transportation, and furthermore, release Trails Grief Camp and staff, or The Equestrian Therapy Program and staff from any liability.

I also accept the responsibility of insurance coverage as listed below:

_____1. We have our own insurance. Name of Insurance Co. _____

Policy Number _____

_____2. We do not have insurance coverage, therefore we are responsible for payment,

(physician, hospital, x-ray, lab, other).

In regards to the camp participant, I submit the following:

1 Allergies to food, stings, medications (If none, write "None".) _____

_____

2. Special Medical concerns. (If none, write "None".) _____

_____

3. Participant needs medications during camp. (Upon arrival, all medications will be given to the camp nurse for dispensing.) MEDICATION _____ DOSAGE _____

When dosage is to be taken _____

_____ YES ____ NO I give permission for my child to be photographed/videotaped for public relations/fund raising purposes.

Family Physician_____ Telephone _____

Family Dentist _____ Telephone _____

Your Telephone Numbers _____ Other _____

If I am unable to transport my participant, I give permission for _____

(relationship) _____ to pick up my participant. (If additional space is needed, use the back of the paper.)

Date _____ Signature _____