Kaleida Health
John R. Oishei Children's Hospital
Child Life Department

Smiling Through Tears

All Day Bereavement Camp for Children

Children ages 5-18 who are grieving the death of a sibling or parent are invited to join us at Taylor Road Log Cabin in Hamburg to learn special ways to share and work through their grief

When: Tuesday July 16th, 2019
Time: 9am-6pm
Where: Taylor Road Family Recreation Facility in Hamburg
Cost: No charge

Application due by July 9th, 2019

If you need to contact us on the day of camp, call Tara at 913-3739, or Maureen at 903-6828

Tentative Schedule

9am-9:30am	Registration and Breakfast
9:30-10:00am	Camp Introductions
10:00-11am	Group Activity
11am-12pm	Group Activity
12pm-1pm	Lunch
1pm-1:30pm	Free Time
1:30-2pm	Group Activity
2:30-3:30pm	Group Activity
3:30-4:30pm	Group Activity
4:30-5pm	Free Time
5pm-6pm	Closing Memorial and Picnic

John R. Oishei Children's Hospital

Permission Slip

Bereavement Day Camp on 7/16/2019 with the
Child Life Department of John R. Oishei Children's Hospital

I ___________________________ give permission for ______________________________ to attend an all day bereavement camp on Tuesday July 16th, 2019 chaperoned by the Growing Through Grief Support Group facilitators Tara Young and Maureen McOwen.

______________________________ Sex: _____ Age: ____
Child's Full Name (please print)

Name of Parent or Guardian: _________________________________
Phone Number of parent or guardian (a number to reach you at during the camp)_____________
Home address:____
Email address:____
*NOTE: In case of emergency, we must be able to locate you or an emergency contact any time during the camp.

Emergency Contact: ________________________ Relationship: ________
Home#: _____________ Work#: ______________ Mobile#: ____________
Home address:____

If applicable: My child(ren) has the following medical condition and/or takes the following medication. * RN is on site the entire day (*please write down any medical conditions i.e. allergies, diabetes, seizure disorder, etc.):*

____
____
____

____
(Signature of Parent or Guardian) (Date)

Number of people who will be attending closing memorial and picnic @5PM_____***Please fill out both sides**

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Bereavement Day Camp

In order for this experience to be as beneficial as possible for your child(ren), please provide us with the following information:

Name of the loved one who died: ________________________________
Loved one's age at time of death: ________________________________
Date of death: ________________________________
Child's relationship with loved one:________________________________

Briefly describe the circumstance surrounding loved one's death (illness, accident, etc..)
____
____
____
____
____

Specific concerns regarding child's grief or related behaviors:
____
____
____
____
____

In addition to the death, has there been any important change in your child's life? Examples: moved to new school, new home, etc.
____
____
____