HOSPICE OF THE Piedmont
KIDS' GRIEF AND HEALING

For office only: C or H

AT: _____

KIDS' GRIEF AND HEALING APPLICATION

Program: ___Individual counseling ___School Group ___Workshop ___Spring Camp ___Fall Camp

Today's Date: _____

Child/Teen's name: _____ Nickname: _____ Age: _____

School grade: _____ Birth date: _____/_____/_____ Gender: Female _____ Male _____

School attending: _____ Guidance Counselor: _____

Parent(s) / Legal Guardian:

_____

_____

Mailing Address:_____

City: _____ County: _____ State: _____ Zip Code:_____

Home phone: (_____)_____ Work phone: (_____)_____ Cell phone: (_____)_____

ParentE-mail address: _____

Loved one's name? _____ Relationship to child/teen: _____

What is the illness or what was the cause of death? _____

Date of death (if occurred): _____

Explain Circumstances (optional): _____

_____

What has the child/teen been told about the illness or death? _____

_____

What spiritual beliefs has the child/teen been taught about death?_____

_____

Please list any concerns (problems with medical or mental health, eating, dietary restrictions, allergies, physical limitations, sleep, relationships, school, other major changes, etc): _____

_____

_____

To the best of my knowledge, the above information is correct and accurate.

_____

Signature of Parent/Guardian Date

675 Peter Jefferson Parkway, Suite 300 Charlottesville, VA 22911 434-817-6900 (fax) 434-245-0251

KIDS' GRIEF AND HEALING INDEMNIFICATION AGREEMENT

I, _____, give permission for my child/teen _____ to participate in the Kids' Grief and Healing programs, which includes, but is not limited to groups at school, community locations or Hos-pice of the Piedmont offices, individual support sessions and camps.

I give permission to Hospice of the Piedmont's counselor(s) to share information via telephone, email, or in person re-garding my child with his or her counselor and for my child to be seen by a Hospice of the Piedmont counselor, individually or in a group at school. _____yes _____no

I give permission for my child/teen to be photographed, videotaped or interviewed and his/her artwork to be photographed during the Kids' Grief and Healing programs under supervision of staff. This material and artwork may be used for future publicity or fundraising for the Kids' Grief and Healing programs, including news media.
_____yes _____no

RELEASE

Telemental Health Services ____ (check if applicable)

I hereby consent to engaging in grief related telemental health counseling via Skype or Zoom. I understand that telemental health counseling may include the practice of grief support, consultation, and education using interactive audio, video, or data communications.

I understand the following with respect to Telemental health services:

I understand that there are risks and consequences from distance counseling, including, but not limited to, the possi-bility, that despite reasonable efforts on the part of my child's counselor, that: the transmission of confidential infor-mation could be disrupted or distorted by technical failures. These risks are offset by my child's bereavement coun-selor's use of Skype for Business or Zoom, HIPPA-compliant services which are encrypted for video telemental health communications. Further, the contents of my child's therapist's computer are encrypted.

In addition, I understand that telemental health services and care may not yield the same results nor be as effective as face to-face service.

In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means, including telephone or secure email. I understand that SMS text messaging (e.g., through my cellular provider) and nonencrypted email are not secure and should not be used to convey confidential information.

It is my responsibility to maintain privacy on the client end of communication. This includes not record-ing telemental health consultations without discussing the risks with my child's counselor.

I understand that there are potential risks and benefits associated with any form of counseling, and that despite my child's efforts and the efforts of my child's counselor, my child's condition may not improve and in some cases may even get worse. I understand that my child may benefit from distance counseling, but that results cannot be guaran-teed or assured.

I acknowledge, however, that if my child may be facing an emergency situation that could result in harm to them or to another person; I am not to seek a telemental consultation for my child. Instead, I agree to seek care for my child immediately through our own local health care counselor or at the nearest hospital emergency department or by calling 911.

In consideration of the above-named child/teen being accepted by Hospice of the Piedmont to attend the Kids' Grief and Healing programs,

I, for myself and on behalf of my child/teen, release and discharge Hospice of the Piedmont, its staff, Board of Directors, Officers, Volunteers, from all claims, demands, actions and judgments, which I or my child/teen ever had or now has or may have against Hospice of the Piedmont for all personal injuries, either physical or emotional, known or unknown, and injury of property, real or personal, sustained by my child/teen's person or property during his or her participation in Kids' Grief and Healing camps or activities, regardless of fault or negligence.

I agree to indemnify and hold harmless Hospice of the Piedmont, for any and all claims, demand, actions and judgments whatsoever of every name and nature, both in law and equity, which my child/teen ever had or now has or may have against Hospice of the Piedmont for all personal injuries, either physical or emotional, known or unknown, and injury to property, real or personal, sustained by my child/teen's person or property during his or her attendance for Kids' Grief and Healing camps or activities, including but not limited to injury caused by negligence.

I, the undersigned, have read this release and understand all of its items. I understand that this content is valid for (1) year from date of signature, or the date my child ends his/her involvement with the Kids' Grief and Healing programs described herein, whichever is later.

_____

Signature of Parent/Guardian Date

IF YOUR CHILD/TEEN WILL PARTICIPATE IN JOURNEYS SPRING OR FALL CAMPS (NOW OR IN THE FUTURE) PLEASE COMPLETE THE FOLLOWING:

Last Tetanus shot (date): _____ Are immunizations up-to-date? _____ yes _____ no

Medications:

_____

Are there any activities your child/teen may not be able to participate in? _____ yes _____ no

If yes, please explain:

_____

T-shirt size: _____

Physician's name:

_____

Hospital of choice:

_____

Emergency contact #1:

_____

Relationship: _____ Email address: _____

Home phone: ( )_____ Work phone: ( )_____ Cell phone: ( )_____

Emergency contact #2: _____

Relationship: _____ mail address: _____

Home phone: ( )_____ Work phone: ( )_____ Cell phone: ( ) _____

I give permission to the staff of the Kids' Grief and Healing programs to administer first aid to my child/teen and au-thorize emergency transport to the nearest acute care facility.

_____ _____

Signature of Parent/Guardian Date

Do you need assistance with transportation to group or camp? _____ yes _____ no

If yes, please sign below:

I give permission for the Kids' Grief and Healing programs staff, volunteers and (as applicable) public transportation services to transport my child/teen to/from Kids' Grief and Healing activities and events.

_____ _____

Signature of Parent/Guardian Date

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