



# CENTER FOR CHILDREN

## APPLICATION

For office only: C or H

AT: \_\_\_\_\_

Program: ☐ Individual counseling ☐ School Group ☐ OASIS ☐ 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: (\_\_\_\_) \_\_\_\_\_

Parent E-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

## CENTER FOR CHILDREN INDEMNIFICATION AGREEMENT

I, \_\_\_\_\_, give permission for my child/teen \_\_\_\_\_ to participate in the Center for Children programs, which includes, but is not limited to groups at school, community locations or Hospice 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 regarding 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 Center for Children programs under supervision of staff. This material and artwork may be used for future publicity or fundraising for the Center for Children 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 possibility, that despite reasonable efforts on the part of my child's counselor, that: the transmission of confidential information could be disrupted or distorted by technical failures. These risks are offset by my child's bereavement counselor'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 recording 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 guaranteed 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 Center for Children 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 Center for Children 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 Center for Children 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 Center for Children programs described herein, whichever is later.

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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 Center for Children programs to administer first aid to my child/teen and authorize emergency transport to the nearest acute care facility.*

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*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 Center for Children programs staff, volunteers and (as applicable) public transportation services to transport my child/teen to/from Center for Children activities and events.*

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*Signature of Parent/Guardian Date*

