2022 Good Grief Camp

Space is limited – Register today!

For more information please call Kaweah Health Hospice at 559-733-0642

Please return the completed form to Kaweah Delta Hospice by Oct. 14th to:
Fax: 733-0658 or Email: jsusee@kaweahhealth.org
In Person: 623 W. Willow Ave. Visalia, CA (Hospice Office / Campus)

Child Name: ____

Address: ____

City / State / ZIP: _________________________________ T-Shirt Size: CS CM CL CXL AS AM AL AXL

Phone / Email: _________________________ ______________________________________

Age___________________ Grade: School: ____

Primary Language spoken at home: _ ___________

Parent / Guardian Name:

____ Relationship to child: _____________

(Please note: student(s) must be accompanied by an adult):

So that we can help your child as much as possible, what is the relationship of the person who died to the child and when did the person die?

Relationship: _______________________________________ How long ago did they die? _____________________

Does the student have any medical conditions we should be aware of?
____

Does the student have any food or other allergies we should be aware of?
____

I, _________________________ grant permission to Kaweah Health Hospice for the use of the photograph(s) or electronic media images from The Good Grief Camp in any presentation of any and all kind whatsoever. I understand that I may revoke this authorization at any time by notifying Kaweah Health Hospice in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived.

I, _________________________ grant permission for ____________________________ to attend the Good Grief Camp sponsored by Kaweah Health Hospice. I understand that all reasonable safety precautions will be taken at all times by Kaweah Health Hospice. I authorize any treatment by an accredited hospital and/or physician deemed necessary for the subject of the release in case of an emergency. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Kaweah Delta Health Care District liable for damages, losses, diseases, or injuries incurred by the subject of this form.

Parent/Guardian PRINTED Name: ____

Signature: _____________________________________ Date: _______________________