



SUNSHINE CAMP 2011
 1414 Physicians Drive, Wilmington, NC 28401
 (910) 796.7991



Please mail this application form with a \$25 check payable to Lower Cape Fear Hospice & LifeCareCenter to the above address.

SUNSHINE CAMP REGISTRATION FORM

Child's Name: _____
 (last) (first) (middle) (name called/ nickname)

Address: _____
 (street) (city) (state) (zip code)

Date of Birth: **Age:** **M** **F** **School:** **Grade in Fall:**

Mother/Guardian's Name: **Daytime Phone #:** **E-MAIL:**

Father/Guardian's Name: **Daytime Phone #:** **E-MAIL:**

SO THAT WE MAY SERVE YOUR CHILD'S INDIVIDUAL NEEDS, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Who lives in the home with your child (parents, brothers & sister, etc.):

Does your child have any medical problems or allergies?

LIST CURRENT MEDICATIONS CHILD IS TAKING:

Has your child previously had any counseling? Explain.

Name of Person(s) who died? **Date of Death:**

Was the deceased person a hospice patient? Yes No

Relationship to child (i.e., mother, grandfather, etc.):

What did the child call this person (i.e., Papa, Nana, etc.):

Cause of death (i.e., heart attack, accident):

Is the child aware of the circumstances concerning the death?

Have you noticed any changes with the child since the death? Please explain:

What questions or concerns has your child expressed since the death?

Are there any other important facts we should know about your child?

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE** _____