PARENT/GUARDIAN INTEREST FORM

We look forward to learning more about the child you are nominating! Please answer the questions the best you can. We will contact you to schedule a follow-up meeting. We cannot guarantee available spots in our program. Thank you for understanding.

CHILD'S INFORMATION

Name:		Preferred name:	Preferred Pronouns:
Birthdate:	Gender:	Race:	Preferred language:
Current Grade and School:		Expected Grade and School next year:	

PARENT/GUARDIAN'S INFORMATION

Name:		Relationship to child:	
Address:			
Phone Number:	Email:		Preferred language:

GENERAL HISTORY & GOALS

How did you hear about the program?
Is the child currently receiving services? (Counseling, etc.)
Has the child processed their trauma with a mental health professional? If yes, with whom, and where? How long?
Is there anything else that would be helpful for us to know in advance?
What do you believe the child will gain from involvement with Camp HOPE America?
Has the child attended an overnight camp in the past? If yes, when? How did it go?

SAFETY

Has the child been exposed to domestic violence or other form of child abuse? What year(s)?
Has the child been in a safe place and out of harm for a minimum of three months?
For safety reasons, is there any person your child should not be in contact with? If yes, please share their Name, Birthdate, and relationship to child.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

In order to determine camper eligibility, we would like to contact your child's therapist, social worker, or other professional who has worked with your child to gather information that will help us assess their readiness for Camp HOPE America. With your permission, we will ask basic questions about the camper's emotional and mental health and how it might positively or negatively manifest in a camp environment.

I, _____ (caregiver), hereby authorize the employees of _____Safe Futures_____ (name of your local Family Justice Center, Multi-Agency Center, or community-based agency) to release mental health information regarding _____ (child's name) for the purposes of assessing my child's readiness for participation in Camp HOPE America. This authorization is in effect until August 31, 2025 when it expires. I understand that by signing this authorization:

- I authorize the use or disclosure of my child's individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my child's health information. If I sign this authorization to use or disclose information, I can revoke it at any time. The revocation must be made in writing and will not affect the information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I represent that I am the caregiver of my child, that I am at least eighteen (18) years of age, and that I am under no mental or legal disability which would prevent me from signing and executing this agreement. I further represent that I have read (or have had read to me) and understand the terms of this agreement.

Signature of Caregiver _____ Date _____

Printed Name of Caregiver _____