



2010 Registration Form

Volunteer Information

First Name: _____ Last Name: _____

Preferred Name: _____

Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

T-Shirt Size (please check one):

Adult: Small Medium Large OX-Large XX-Large

In Case of Emergency Information

Emergency Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____ Alt. Phone: _____

Medical Information

Name of Company: _____ Telephone # of Company: _____

Policy Number: _____ Policy Holder's Name: _____

Policy Number's Social Security Number (if needed): _____

Food Allergies: _____ Drug Allergies: _____

Other Significant Allergies: _____

Please list any dietary restrictions: _____

I give permission to agents of High Country Health Care Systems Hospice to administer first aid and authorize emergency transport to the nearest acute care facility.

Volunteer Signature: _____ **Date:** _____

Bereavement History

(Please include as many details as possible when answering the following questions.)

1. Have you ever lost a family member or friend? _____
2. What was your relationship to that person? _____
3. What was the cause of death? _____
4. When did the death occur (date)? _____
5. How old were you when the death occurred: _____
6. How many losses have you had? _____ Please describe: _____

7. Have you worked through this loss? _____
8. How have you helped younger children in the past? _____
9. Please explain why you would like to help with Camp Sunshine: _____

10. Please list any special talents/gifts/interests you have: _____

11. How did you hear about Camp Sunshine? _____

Final Camp Information

I give permission to be photographed, videotaped, or interviewed during Camp Sunshine knowing that this material may be used for Hospice promotion, education, and general Hospice usage. **(Initial)** Yes _____ No _____

I _____, release High Country Health Care Hospice (employees, volunteers, directors, officers) from all liabilities, losses, cost, damages, claims, or causes of action of any kind and expenses, including attorney's fee, arising or claimed to have arisen out of any injuries or damages received or sustained by any person or persons or property as a result of intentional acts.

Volunteer Signature: _____ **Date:** _____

I have read, answered, and understood the above information.

Volunteer Signature: _____ **Date:** _____

Please mail your application to:

Watauga

Attn Jennifer Johnson
136 Furman Road St. 4
Boone NC 28607

Ashe

Attn Jennifer Richardson
PO Box 421
Jefferson, NC 28640

Alleghany

Attn Mary Lee
PO Box 1287
Sparta, NC 28675

If you have questions call your local Hospice office or visit our website highcountryhospice.org:

Alleghany Hospice: 336.372.8018

Ashe Hospice: 336.246.6443

Watauga Hospice: 828.265.3926