



Parents and Teens: Please complete the following

CONNECT PROGRAM ASSESSMENT

Name \_\_\_\_\_
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ [ ] male [ ] female

Name of Deceased: \_\_\_\_\_ Relationship to Deceased \_\_\_\_\_
Date of Death: \_\_\_\_\_ Age: \_\_\_\_\_ Calvert Hospice Patient? [ ] Yes [ ] No

Circumstances of Death: \_\_\_\_\_

Who informed you of the death and how was that done? \_\_\_\_\_

Response to the death: \_\_\_\_\_

Medical history (serious illness, injuries, operations, physical disabilities, general medical condition, any medications): \_\_\_\_\_

Prior experiences with death/loss: \_\_\_\_\_

Participation with funeral services: \_\_\_\_\_

Have there been any additional losses (moving, changing schools, parental separation, etc.) \_\_\_\_\_

Are Teachers and Guidance Counselors aware of the death? Yes \_\_\_ No \_\_\_

Progress/Problems at School? \_\_\_\_\_

Have you experienced any trouble reading/writing or have any special learning needs? \_\_\_\_\_

Please complete the first two columns by reviewing the following list and indicating if item is an issue.

**N=Not a problem S=Slight problem (occasionally) M=Moderate Problem (sometimes)  
E=Excessive (always)**

	Behavior present before death	Behavior new Since Death
Sleeping too much or too little (circle which)		
Appetite Increase or Decrease (circle which)		
Weight Increase or Decrease (circle which)		
Nightmares		
Headaches		
Fatigue		
Stomach aches		
Anxiety		
Denial about death		
Anger Problems		
Guilt		
Rebellious		
Difficulty Concentrating		
Changes in grades Increase or Decrease (circle which)		
Being very loud/noisy		
Temper Outbursts		
Fighting		
Defiant		
Lack of energy		
Clinging to parent/adult		
Desire to sleep with parent/sibling		
Desire to have constant attention		
Insecure		
Not getting along with friends		
Concerns about Alcohol/Drug Use**		
Known Alcohol/Drug use**		
Suspect Cigarette Smoking**		
Known Cigarette Smoking**		
Self-Injurious Behavior (cutting, burning, anorexia, bulimia etc.)**		
Other (add here or on separate sheet)		

\*\*If you indicated there is an issue with these items, please add additional information.

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**Parent /Guardian Signature**

**Date**



## CONNECT PROGRAM

### Informed Consent, Release and Indemnification Agreement

I, \_\_\_\_\_ hereby give permission for my child, \_\_\_\_\_, to attend the CONNECT Program beginning Wednesday, May 3, 2017 and ending on Wednesday, June 21, 2017, from 6:00 pm to 7:30 pm every Wednesday evening for 8 weeks, at CSM – Prince Frederick campus, Room 225.

He/She agrees and will commit to attending all eight (8) sessions of the CONNECT Program.

1. I understand the goal of CONNECT is to help facilitate my child’s bereavement process and provide support for him or her in expressing feelings of grief.
2. AUTHORIZATION is hereby granted to release and obtain from appropriate agencies, school personnel, health and mental health providers, such information as may assist Calvert Hospice CONNECT Program personnel in the furtherance of support for my child.
3. RELEASE: I give my permission for my child to be photographed during CONNECT. I agree that these photographs are and remain the property of Calvert Hospice and that these images may now or in the future be used by Calvert Hospice for promotional and/or educational purposes in any medium, including but not limited to, print materials, in digital or electronic form, and/or on the Calvert Hospice website .
4. In consideration of the above-named child being granted permission by Calvert Hospice to attend the CONNECT Program, I, for myself and on behalf of my child, release and discharge Calvert Hospice, its agents, employees, volunteers, officers, and directors from all claims, demands, actions and judgments which I or my child has had, now has, or may in the future have against Calvert Hospice for any personal injury, physical or emotional, known or unknown, and any injury to property during my child’s attendance at CONNECT, whether the injury is caused by negligence or any other fault.
5. INDEMNIFICATION AGREEMENT: In consideration of the above-named child being granted permission by Calvert Hospice to attend the CONNECT Program, I agree to indemnify and hold harmless Calvert Hospice for any and all claims, demands, actions and judgments whatsoever in law and equity, which my child has had, now has or may in the future have against Calvert Hospice for all Hospice for any personal injury, physical or emotional, known or unknown, and any injury to property during my child’s attendance at the CONNECT Program, including, but not limited to injury caused by or arising out of negligent conduct by Calvert Hospice agents, employees, volunteers, officers and directors.

I, the undersigned, have read this release and understand all of its terms.

Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

### GROUP PARTICIPATION CONTRACT

~ Everything said in the group is CONFIDENTIAL.

~ The group will meet once a week for eight (8) sessions from 6:00-7:30 p.m. The group ends and begins on time.

~ I commit to attending all eight (8) sessions.

~ **If there is an emergency and I cannot attend, I will notify the CONNECT Group facilitator, Brittany Petrzala, before the meeting. (410) 535-0892, x2206.**

Teen: \_\_\_\_\_

Date: \_\_\_\_\_





## Bereavement Services Intake Form

*Parent/Guardian: Please complete with your information.*

Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Phone #'s    H \_\_\_\_\_    W \_\_\_\_\_  
                  C \_\_\_\_\_    Email \_\_\_\_\_  
Employer: \_\_\_\_\_    Occupation \_\_\_\_\_  
Names/Ages Of Those Living In Your Home: \_\_\_\_\_  
Name of Deceased: \_\_\_\_\_ Relationship \_\_\_\_\_  
Date of Death: \_\_\_\_\_ Age at Death: \_\_\_\_\_ Cause of Death: \_\_\_\_\_  
In Case of Emergency, Who Should We Contact: \_\_\_\_\_  
How did you hear about this program? \_\_\_\_\_

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