

Expressing Ourselves
Monthly Grief Support
Application & Prescreening Form

Mail To: Hospice of the Upstate
1835 Rogers Rd.
Anderson, SC 29621

Participant's Name(s) _____ Group Date _____

Parent or Guardian _____

Address _____

_____ Phone Numbers _____

Emergency Contact & Phone _____

Allergies _____

Behavioral Concerns or Issues _____

Briefly explain the type and nature of the loss experienced by the child. (Please include dates, reason or causes, duration of illness and relationship to the child.) Use back if necessary. This information will be held confidential and is for group leaders to properly prepare themselves for the needs of the child. When this application is submitted (mail or drop off at Hospice House), *please mark: Confidential Application: attention Lauren Bishop*, and place in a sealed envelope. You will be notified by phone when your child is registered. Please send no money at this time. If you would like to help cover the costs of snacks or materials, we suggest a \$5.00 donation to Children's Outreach Programs which may be brought to the group you attend. If you are unable to attend the group, please contact us as soon as possible so that we may register another applicant. Thank You, we look forward to an opportunity to support you and hope that this program will benefit your family.

I agree to allow my child to participate in this grief group.

Signature _____ Date _____

*All personal information is confidential; however,
My child may be interviewed or photographed for possible educational use or to promote
children's programming.

Yes ___ No ___