Registration Form

Registration date: _____

Instructions:

1. Complete the **Family Information**
2. Read **Participation Waiver and Consent**
3. Complete a **Program Registration** section and Complete an ACE Score (Adverse Childhood Experiences) for each family participant
4. Go through the **Checklist for Enrollment** to make sure your enrollment in services is finalized
5. Complete **Suggested Donation** section on page 12

Family Information

Primary Family Contact Information

Please list the primary family contact information below

Last name: _____ First name: _____ Middle Initial: ___

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Employer: _____

Primary phone: _____ ☐ Cell ☐ Home ☐ Work

Alternative phone: _____ ☐ Cell ☐ Home ☐ Work

Email: _____

Preferred method of contact (check all that apply): ☐ Email ☐ Home phone ☐ Work phone ☐ Cell phone: ☐ Text ☐ Voicemail

Emergency contact name: _____ Relationship: _____

Emergency contact phone: _____ ☐ Cell ☐ Home ☐ Work

Family Demographic Information

Number of people in your household: _____

Annual family income level:

☐ $1–$14,999 ☐ $15,000-$24,999 ☐ $25,000-$34,999 ☐ $35,000-$49,999
☐ $50,000-$74,999 ☐ $75,000-$99,999 ☐ $100,000-$124,999 ☐ $125,000-$149,999
☐ $150,000-$174,999 ☐ $175,000-$199,999 ☐ $200,000-$249,999 ☐ $250,000+ ☐ Prefer not to answer

Is your child(ren) eligible for free and reduced lunch? ☐ Yes ☐ No ☐ N/A

Has the death of your loved one affected your financial condition? ☐ Yes ☐ No

If yes, how so: _____

Have you experienced unemployment due to the death of your loved one? ☐ Yes ☐ No

Have you experienced homelessness due to the death of your loved one? ☐ Yes ☐ No

Family's religious affiliation: _____

Are other immediate family member(s) registering for services: ☐ Yes ☐ No

If yes, please complete a Registration and Waiver for each person including yourself (page 3)

Who are you registering? (check all that apply): ☐ Myself ☐ My children ☐ Other: _____

Tell us about the loved one you are remembering . . .

Name: _____ Date of Death: _____ Age: _____

Cause of Death: _____ Where did death occur? _____

Can you tell us how you learned about Amanda the Panda?

☐ Friend or family member ☐ Funeral home:_____

☐ Hospice: _____ ☐ Healthcare worker : _____

☐ School:_____ ☐ Mental health professional: _____

☐ Another EveryStep team: _____

☐ Other:_____

If you heard about EveryStep Grief & Loss Services, home of Amanda the Panda through another professional, please share which agency and staff member referred our program:

_____

_____

Participation Waiver and Consent

PLEASE REVIEW THE RELEASE AND CONSENT PORTION BELOW AND SIGN THE WAIVER & CONSENT SECTION FOR EACH PARTICIPANT

(Registration and Waiver sections for each participant begin on page 3)

AMANDA CARES, INC. PARTICIPANT RELEASE AND CONSENT

I, the undersigned* Participant, intending to be legally bound, understand and agree that I am voluntarily participating in an activity or activities sponsored by Amanda Cares, Inc. d/b/a Amanda the Panda ("ATP"), including, but not limited to, Camp Amanda®, support group, or Fun Day ("ATP Activities"), at my own request and at my own risk. I acknowledge that I am aware of the risks inherent in participating in ATP Activities and certify that I am physically fit and have not been otherwise informed by any physician and know of no restrictions imposed on me by any physician that would in any way prevent me from actively participating in ATP Activities.

In consideration of ATP's sponsorship of ATP Activities and my being permitted to participate in ATP Activities, I, on behalf of myself and my successors, assigns, agents, insurers, attorneys, heirs, executors, administrators, and representatives, hereby fully release and hold harmless ATP, its directors, officers, trustees, agents, employees, representatives, volunteers, donors, and any medical providers working for or on behalf of ATP, and each of their respective successors and assigns (be they individuals or organizations), together with each of their insurers and sponsors, of and from any and all claims, actions, causes of action (whether arising in contract, tort, by statute or otherwise), demands, debts, liabilities, rights, damages, costs, loss of services, expenses, compensation, third---party actions, suits at law or in equity, including claims or suits for contribution and/or indemnity, of whatever nature (including, but not limited to, any claim relating to alleged wrongful death), including all consequential, exemplary, or punitive damages, suffered by me at any time hereafter arising out of my voluntary participation in ATP Activities.

I also grant permission to ATP to render preventative or first-aid assistance or seek treatment or medical care that ATP or any medical providers working for or on behalf of ATP deem reasonably necessary, including hospitalization, for my health and well-being.

I agree to an evaluation of complicated grief and program-specific assessment, which will involve completion of ATP and industry assessment tools. Only teen and adult participants will be asked to complete evaluations. Evaluation is voluntary, and I may refuse to participate at any time. As the guardian/parent, I agree to let any minors participating in the young adult/teen group complete the screening assessment and program evaluation.

I also give permission to ATP to freely use my name, image, picture, and voice in any broadcast, telecast, print account, or any other account in any medium. I understand that this release is perpetual in time and that it encompasses, without limitation, any copyright or right of publicity or privacy that I may have in my name, image, picture and voice.

I understand that my information contained in this registration packet can be shared with staff and volunteers.

I acknowledge by signing this that my deposit may be cashed if I do not provide notice one week before services begin that I will no longer be taking part in services to which I have enrolled.

Please complete and sign the Waiver & Consent portion in each participant's registration below.

Please complete participant registration, waiver, and ACE Score for each individual signing up for programming.

Program Registration

Participant Registration and Waiver

Last name:_____ First name: _____ Middle Initial: _____

Date of birth:_____ Grade in school *(if applicable)*: _____

What is the highest level of education you have completed? _____

Due to the loss of your loved one, how many days of school have you missed? _____

Same address listed on page 1: ☐ Yes ☐ No

If No, please provide other address: _____

Relationship to loved one you are remembering: _____

Which program(s) are you registering for:

Support group session**:** ☐ Winter ☐ Spring ☐ Summer ☐ Fall

Over-night/Weekend Camp**:** ☐ Spring ☐ Fall Day Camp: ☐ Winter ☐ Summer

Gender: ☐ Male ☐ Female ☐ _____ Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Primary race you identify with: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Multi-racial
☐ Other ☐ I prefer not to answer

Ethnicity you identify with: ☐ Hispanic ☐ Non-Hispanic ☐ I prefer not to answer

Please select the form of insurance do you have:

☐ Blue Cross Blue Shield ☐ Aetna ☐ Cigna ☐ United Health Care Commercial ☐ Medicaid _____
☐ Gundersen Health Plan Inc. ☐ Wellmark ☐ Stanford Health Plan ☐ Other _____

How many times have you been to the doctor in the last 90 days? _____

What is your profession/occupation? _____

If employed, how many bereavement days were you allotted by your workplace? _____

Due to your loss, how many days of work have you missed? _____

Have you ever been hospitalized or attended inpatient treatment for mental health or substance use due to struggles associated with the loss of your loved one? ☐ No ☐ Yes: _____

Due to the loss of your loved one, have you experienced legal troubles? ☐ No ☐ Yes: _____

Any health problems we should be aware of? ☐ No ☐ Yes: _____

Any special dietary needs? ☐ No ☐ Yes: _____

Any allergies staff need to be concerned about? ☐ No ☐ Yes: _____

Any medications needed during Camp Amanda*? ☐ No ☐ Yes: _____

*At Amanda the Panda, your health is of utmost concern to our volunteers and staff. Please inform us of any medication needs that will take place during your participation at Camp Amanda (example: rescue inhaler for asthma, as needed with physical activity). Any child participating in Camp Amanda will need to have trained ATP Staff/Volunteers securely store and administer medication. Adult participants are responsible for their own medication administration.

Any behavior problems we should be aware of? ☐ No ☐ Yes: _____

Are you currently seeking mental health counseling/therapy from a professional? ☐ No ☐ Yes

If no, are you interested in information about counseling/therapy services? ☐ No ☐ Yes

Participant Release & Consent– MUST be signed for each Participant

If 18 years or older: I have read the Participant Release and Consent on Page 2 and acknowledge that I fully understand and agree to the stated terms.

*Participant Signature**	*Printed Name*	*Date*

*Must be signed by parent or legal guardian if the Participant is under age 18 on the date this Release and Consent is signed.

If under age 18: I, the undersigned, hereby certify that I am the parent or legal guardian of the Participant, and sign this Release and Consent on behalf of the Participant and myself.

Parent/Guardian Signature	*Printed Name*	*Date*

ACE Score (Adverse Childhood Experiences)

Please complete this survey for each participant registering for programming. Participants 14+, please complete on your own, participants 5-13 please have caretaker complete.

From birth to 18 years of age:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No☐ Yes☐

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No☐ Yes☐

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No☐ Yes☐

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No☐ Yes☐

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your caretakers were too drunk or high to take care of you or take you to the doctor if you needed it?
   No☐ Yes☐

6. Were your parents ever separated or divorced?
   No☐ Yes☐

7. Were your parents or other adults in the household:
   Often or very often pushed, grabbed, slapped, or had something thrown at them by their significant other? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No☐ Yes☐

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No☐ Yes☐

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   No☐ Yes☐

10. Did a household member go to prison?
    No☐ Yes☐

Now add up your "Yes" answers: ___ *(*This is your ACE Score)

Program Registration

Participant Registration and Waiver

Last name:_____ First name: _____ Middle Initial: _____

Date of birth:_____ Grade in school *(if applicable)*: _____

What is the highest level of education you have completed? _____

Due to the loss of your loved one, how many days of school have you missed? _____

Same address listed on page 1: ☐ Yes ☐ No

If No, please provide other address: _____

Relationship to loved one you are remembering: _____

Which program(s) are you registering for:

Support group session: ☐ Winter ☐ Spring ☐ Summer ☐ Fall

Overnight/Weekend Camp: ☐ Spring ☐ Fall Day Camp: ☐ Winter ☐ Summer

Gender: ☐ Male ☐ Female ☐ _____ Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Primary race you identify with: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Multi-racial
☐ Other ☐ I prefer not to answer

Ethnicity you identify with: ☐ Hispanic ☐ Non-Hispanic ☐ I prefer not to answer

Please select the form of insurance do you have:

☐ Blue Cross Blue Shield ☐ Aetna ☐ Cigna ☐ United Health Care Commercial ☐ Medicaid _____
☐ Gundersen Health Plan Inc. ☐ Wellmark ☐ Stanford Health Plan ☐ Other _____

How many times have you been to the doctor in the last 90 days? _____

What is your profession/occupation? _____

If employed, how many bereavement days were you allotted by your workplace? _____

Due to your loss, how many days of work have you missed? _____

Have you ever been hospitalized or attended inpatient treatment for mental health or substance use due to struggles associated with the loss of your loved one? ☐ No ☐ Yes: _____

Due to the loss of your loved one, have you experienced legal troubles? ☐ No ☐ Yes: _____

Any health problems we should be aware of? ☐ No ☐ Yes: _____

Any special dietary needs? ☐ No ☐ Yes: _____

Any allergies staff need to be concerned about? ☐ No ☐ Yes: _____

Any medications needed during Camp Amanda*? ☐ No ☐ Yes: _____

*At Amanda the Panda, your health is of utmost concern to our volunteers and staff. Please inform us of any medication needs that will take place during your participation at Camp Amanda (example: rescue inhaler for asthma, as needed with physical activity). Any child participating in Camp Amanda will need to have trained ATP Staff/Volunteers securely store and administer medication. Adult participants are responsible for their own medication administration.

Any behavior problems we should be aware of? ☐ No ☐ Yes: _____

Are you currently seeking mental health counseling/therapy from a professional? ☐ No ☐ Yes

If no, are you interested in information about counseling/therapy services? ☐ No ☐ Yes

Participant Release & Consent– MUST be signed for each Participant

If 18 years or older: I have read the Participant Release and Consent on Page 2 and acknowledge that I fully understand and agree to the stated terms.

*Participant Signature**	*Printed Name*	*Date*

*Must be signed by parent or legal guardian if the Participant is under age 18 on the date this Release and Consent is signed.

If under age 18: I, the undersigned, hereby certify that I am the parent or legal guardian of the Participant, and sign this Release and Consent on behalf of the Participant and myself.

Parent/Guardian Signature	*Printed Name*	*Date*

ACE Score (Adverse Childhood Experiences)

Please complete this survey for each participant registering for programming. Participants 14+, please complete on your own, participants 5-13 please have caretaker complete.

From birth to 18 years of age:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No☐ Yes☐
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No☐ Yes☐
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No☐ Yes☐
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   No☐ Yes☐
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your caretakers were too drunk or high to take care of you or take you to the doctor if you needed it?
   No☐ Yes☐
6. Were your parents ever separated or divorced?
   No☐ Yes☐
7. Were your parents or other adults in the household:
   Often or very often pushed, grabbed, slapped, or had something thrown at them by their significant other? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No☐ Yes☐
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No☐ Yes☐
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   No☐ Yes☐
10. Did a household member go to prison?
    No☐ Yes☐

Now add up your "Yes" answers: ___ *(*This is your ACE Score)

Program Registration

Participant Registration and Waiver

Last name:_____ First name: _____ Middle Initial: _____

Date of birth:_____ Grade in school *(if applicable)*: _____

What is the highest level of education you have completed? _____

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Which program(s) are you registering for:

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Gender: ☐ Male ☐ Female ☐ _____ Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Primary race you identify with: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native
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☐ Other ☐ I prefer not to answer

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Please select the form of insurance do you have:

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What is your profession/occupation? _____

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Due to the loss of your loved one, have you experienced legal troubles? ☐ No ☐ Yes: _____

Any health problems we should be aware of? ☐ No ☐ Yes: _____

Any special dietary needs? ☐ No ☐ Yes: _____

Any allergies staff need to be concerned about? ☐ No ☐ Yes: _____

Any medications needed during Camp Amanda*? ☐ No ☐ Yes: _____

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Are you currently seeking mental health counseling/therapy from a professional? ☐ No ☐ Yes

If no, are you interested in information about counseling/therapy services? ☐ No ☐ Yes

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*Participant Signature**	*Printed Name*	*Date*

*Must be signed by parent or legal guardian if the Participant is under age 18 on the date this Release and Consent is signed.

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3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
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   No☐ Yes☐
6. Were your parents ever separated or divorced?
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8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No☐ Yes☐
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   No☐ Yes☐
10. Did a household member go to prison?
    No☐ Yes☐

Now add up your "Yes" answers: ___ *(*This is your ACE Score)

Program Registration

Participant Registration and Waiver

Last name:_____ First name: _____ Middle Initial: _____

Date of birth:_____ Grade in school *(if applicable)*: _____

What is the highest level of education you have completed? _____

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Overnight/Weekend Camp: ☐ Spring ☐ Fall Day Camp: ☐ Winter ☐ Summer

Gender: ☐ Male ☐ Female ☐ _____ Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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Ethnicity you identify with: ☐ Hispanic ☐ Non-Hispanic ☐ I prefer not to answer

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Any health problems we should be aware of? ☐ No ☐ Yes: _____

Any special dietary needs? ☐ No ☐ Yes: _____

Any allergies staff need to be concerned about? ☐ No ☐ Yes: _____

Any medications needed during Camp Amanda*? ☐ No ☐ Yes: _____

*At Amanda the Panda, your health is of utmost concern to our volunteers and staff. Please inform us of any medication needs that will take place during your participation at Camp Amanda (example: rescue inhaler for asthma, as needed with physical activity). Any child participating in Camp Amanda will need to have trained ATP Staff/Volunteers securely store and administer medication. Adult participants are responsible for their own medication administration.

Any behavior problems we should be aware of? ☐ No ☐ Yes: _____

Are you currently seeking mental health counseling/therapy from a professional? ☐ No ☐ Yes

If no, are you interested in information about counseling/therapy services? ☐ No ☐ Yes

Participant Release & Consent– MUST be signed for each Participant

If 18 years or older: I have read the Participant Release and Consent on Page 2 and acknowledge that I fully understand and agree to the stated terms.

*Participant Signature**	*Printed Name*	*Date*

*Must be signed by parent or legal guardian if the Participant is under age 18 on the date this Release and Consent is signed.

If under age 18: I, the undersigned, hereby certify that I am the parent or legal guardian of the Participant, and sign this Release and Consent on behalf of the Participant and myself.

Parent/Guardian Signature	*Printed Name*	*Date*

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3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
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   No☐ Yes ☐
6. Were your parents ever separated or divorced?
   No☐ Yes ☐
7. Were your parents or other adults in the household:
   Often or very often pushed, grabbed, slapped, or had something thrown at them by their significant other? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No☐ Yes ☐
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No☐ Yes ☐
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   No☐ Yes ☐
10. Did a household member go to prison?
    No☐ Yes ☐

Now add up your "Yes" answers: ___ *(*This is your ACE Score)

Checklist for Enrollment

☐ Complete entire enrollment form for all people in your family attending services.

☐ Tour Amanda's House

☐ We offer childcare for children whose parents are participating in support group. If you will need childcare during support group, please fill out a Participant Registration and Waiver form for each child.

We ask for a $35 suggested donation per participant (not exceeding $100/family) so that we can continue providing support to others in our community. Are you able to give at this time?

☐ Yes, count me in for a $_____ donation.

☐ No, I am not able to give at this time.

☐ **Options for submitting your donation (select one):**
☐ Mail cash or check to 1821 Grand Ave. West Des Moines, IA 50265.
☐ Drop off cash or check during office hours at 1821 Grand Avenue, West Des Moines, IA 50265.
Visit www.everystep.org/services/grief-loss and click the green "Donate" button, and leave a memo with your name and program you're registering for.

Thank you so much for your contributions to our programming.

Upon completing this form please return to our office by one of the following ways:

- Click the submit button below to email it to our office (be sure to send your donation in the mail)
- Save the pdf and attach it to an email and send to griefandloss@everystep.org
- Print and mail the registration to: Amanda the Panda, 1821 Grand Avenue, West Des Moines, IA 50265

For Office Use Only

Registration

Received Date: _____ Staff: _____

Donation

Received Date: _____ Check #: _____ Amount: _____ Donation Date: _____

Notes: _____

_____