

CHILDREN'S GRIEF SUPPORT

Adirondack Sprouts Children's Grief Support Group Application





What We Do

Adirondack Sprouts Grief Support Program helps children who are grieving the death of a loved one. Trained facilitators use art and music-based, age-appropriate curriculum that educates about grief and provides a safe space for your child to express themselves, process their loss, and find peer support. Adirondack Sprouts runs for 8 weeks.



Who We Serve

Adirondack Sprouts Grief Program is for children aged 6-12 from all economic, racial, ethnic, and religious backgrounds. The program is free for all participants. Funding is provided by High Peaks Hospice.



How We Do It

ADK Sprouts uses an age-appropriate, arts and nature-based curriculum that seeks to educate about grief, support healthy coping skills, and help your child find support through peers and connection to the beautiful outdoors.

Any child, 6-12 years old, who has experienced any type of death in their lifetime, regardless if the loved one was on hospice, is welcome to apply.

An application is required. Space is limited, so please apply as soon as possible.

Return to: High Peaks Hospice 1247 Dix Hudson Falls, NY 12839 Questions/Information (518)891-0606 highpeakshospice.org



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ADK SPROUTS CHILDREN'S GRIEF SUPPORT



Child's Name:	DO	В:	Preferred Pronouns:	Gender:							
Street Address:											
City:	State:		Zip Code:								
Grade:	School:										
Who referred your child: (please check one of the following)											
Physician Therapist/Counselor Parent/Guardian Family Member Teacher Other											
My Child is attending ADK Sprouts Grief Support Group due to the death of: (please check one of the following)											
Father	Grandfather		☐ Brother (aged)	Cousin							
Mother	Grandmother	🗌 Aunt	Sister (aged)	Other							
Use this section to give a brief synopsis of the nature of the death. (If more space is needed, please continue on the back)											
Use the following space to describe any changes in your child's thoughts, feelings, or behaviors you have noticed since the death. (ie: crying, physical symptoms, fearfulness, anger, withdrawal, trouble sleeping, difficulties at schooletc) (If more space is needed, please continue on the back)											
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ADK SPROUTS

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Contact Information:									
Parent/Guardian Name:									
Home Phone: () -	Mobile Phone:	()	-	Work Phone: ()	-			
I give High Peaks Hospice permission to send to this email address weekly emails during the group session with updates/reminders and additional grief resources:YesNo Email:									
<u>In case of emergency, notify:</u> Name:	Primary Phone: ()	-	Additional Phone: ()				
<u>Pick-Up Person:</u> Name:	Primary Phone: ()	-	Additional Phone: ()	-			
<u>Alternate Pick-Up Person:</u> Name:	Primary Phone: ()	-	Additional Phone: ()	-			

By signing below, I give my child permission to participate in Adirondack Sprouts Grief Support Group.

Please check below if you do or do not give permission for your child to be photographed by High Peaks Hospice and ADK Sprouts Grief Support Program to be shared on social media and/or marketing materials for High Peaks Hospice and ADK Sprouts Grief Support Program.

____ I do

____ I do not

Parent/Guardian Signature:

Date:

Please complete ONE APPLICATION PER CHILD

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