HEARTLIGHT CENTER

Starfish

Group support for grieving children

Group Application

Date_____ Child's Date of Birth_____ Child's Age_____

Child's Name_____ Male___ Female___

Address_____

Name of Parent or Guardian_____

Address _____

Home Phone_____ Cell Phone_____ Email_____

Emergency Contact_____

Name of Person who died _____

Date Person died _____ Cause of Death _____

Relationship to the child _____

Has the child been made aware of the cause of death? ___Yes ___No

Please complete the following Family History

Any History Of	Please Check One	Family Member Affected / Relationship to Child
Substance or Alcohol Abuse	___Yes ___No	
Mental Illness	___Yes ___No	
Depression	___Yes ___No	
Sexual or Physical Abuse	___Yes ___No	
Suicide attempts or thoughts of suicide	___Yes ___No	

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Please list any other deaths the child has experienced and the approximate date (friends, relatives, pets)

_____

_____

Has the child received counseling in the past or currently? (if yes, please provide when and with whom) ___Yes ___No _____

Has the child attended a support group in the past or currently? (if yes, please provide when and with whom) ___Yes ___No _____

Is the child taking any medications? (if so, please list all medications)
___Yes ___No _____

_____

Since the death, has the child experienced any of the following?

___Yes ___No a move
___Yes ___No a change in schools
___Yes ___No grade change
___Yes ___No changes in activities
___Yes ___No changes in friends or peer interactions
___Yes ___No death of a pet
___Yes ___No divorce, separation or remarriage in the immediate family
___Yes ___No changes in sleeping patterns
___Yes ___No changes in eating habits
___Yes ___No nightmares
___Yes ___No extreme fears
___Yes ___No bed-wetting
___Yes ___No temper tantrums
___Yes ___No emotional withdrawal
___Yes ___No acting out at school

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About the caregiver…

What is your relationship to the deceased?

_____

Are you receiving counseling? _____

Are there other significant losses that you have experienced in the last 24 months?

_____

_____

Are there any current crises? _____

_____

How is your general health and energy level? _____

_____

How do others feel you are coping? _____

_____

Please describe your support system (eg: family, friends, spouse, sibling, etc.)

_____

_____

Are there other family members who would like to attend group? If so, who and what is their relationship to the child? _____

_____

Are there other problems or concerns you would like to share with us? _____

_____

_____

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Is there any additional information we should know?

_____

_____

_____

Please return this form to:

The Starfish Program
c/o HeartLight Center
11150 E. Dartmouth Ave.
Aurora, CO 80014
emily@heartlightcenter.org