OPTIMAL
HOSPICE FOUNDATION
A BRISTOL HOSPICE PARTNER

Kids Camp
Referral Form

(Please Print Clearly)

Child's Full Name _____Gender _____

Address _____

City _____ Zip _____

Parent/Guardian _____ Relationship to Child _____

Home Phone _____Cell Phone _____

Age ___ Date of Birth _____ School _____

Person Referring _____ Phone Number _____

Organization/School Referring _____

Name of the person who died _____

How was the deceased related to the child? _____

How long ago did the death occur? _____

Please provide any additional information regarding the child or family you feel may be helpful regarding this referral:

_____

_____

_____

_____

_____

*Registration Packets will be mailed to parent/guardian in June.

Please check one

Fresno (Mid-July) ___ (Ages 6-16) Bakersfield (Late July/Early August) ____ (Ages 6-16) NORCAL (Mid-August) ___ (Ages 8-16)

Return to Optimal Hospice Foundation

1227 Chester Avenue Bakersfield, CA 93301 or fax to 661.387.7151

For more information on Kids Camp or the Foundation visit our website

www.optimalhospicefoundation.com or call the Foundation office at 661.716.8000