



# THE STARFISH PROGRAM

## 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 \_\_\_\_\_ Work  
Phone \_\_\_\_\_

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	

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



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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 \_\_\_\_\_

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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

### ***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? \_\_\_\_\_



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Are there any current crises? \_\_\_\_\_

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How is your general health and energy level? \_\_\_\_\_

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How do others feel you are coping? \_\_\_\_\_

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Please describe your support system? \_\_\_\_\_

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

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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? \_\_\_\_\_

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Please return this form to:

**The Starfish Program**  
**c/o Leslie Clemensen**  
**Douglas County School District**  
**620 Wilcox Street**



**THE STARFISH PROGRAM**

**Castle Rock, CO 80104**