MOURNING HOPE GRIEF CENTER

School-Based Grief Support Group Registration

Date: _____

Parent/Guardian Name: _____

Relationship to Youth: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____

Email Address: _____

Youth who will be participating in the group:

Child/Teen Full Name	Date of Birth	Age	Grade

Are there any language, disability and/or religious needs we should be aware of? ____ No ____ Yes *(please explain):*

_____

Are there any other special needs, family customs or cultural aspects we should be aware of? ____ No ____ Yes *(please explain):* _____

Name of the person who died: _____

Relationship to youth: _____ Date of death: _____

Cause of death: _____ Age at death: _____

Was this person's death sudden or anticipated? (*Please explain):* _____

_____

Was the child(ren)/teen(s) present at the time of death? ____ No ____ Yes

Please indicate if either statement is true: ____ Youth has/have NOT been told ALL the facts about how the person died

____ Youth has/have been told the facts, but still has/have questions

Please provide details: _____

_____

_____

Did the child(ren)/teen(s) attend the funeral and/or memorial service? ____ No ____ Yes

If "No," what were their thoughts and reactions to not attending? If "Yes," what were their reactions to the service?

_____

_____

_____

Is/are the child(ren)/teen(s) able to speak openly of the person who died? ____ No ____ Yes *(please explain):*

_____

_____

Who at school is aware that someone significant in the child(ren)'s/teen(s)' life has died?

_____

Reaction to the Loss *Please circle any behaviors that the child(ren)/teen(s) has/have exhibited since experiencing the death.*					
☐	Lack of energy	☐	Behavior problems at school	☐	Nightmares
☐	Withdrawn/isolated	☐	Behavior problems at home	☐	Night sweats
☐	Depression	☐	Loss of interest in friends	☐	Regression – bedwetting
☐	Anger	☐	Loss of interest in activities	☐	Regression – thumb sucking
☐	Anxiety	☐	Changes in school attendance	☐	Headaches
☐	Sadness	☐	Running away from home	☐	Stomachaches
☐	Suicidal thoughts/talk	☐	Hyperactive/impulsive	☐	Sleep disturbances
☐	Causing harm to self	☐	Changes in self-esteem	☐	Sleep walking
☐	Causing harm to others	☐	Difficulty concentrating	☐	Decrease in weight
☐	Drug/alcohol use	☐	Belief that death was his/her fault	☐	Increase in weight
☐	Sexual activity	☐	Worries about his/her safety	Other:	
☐	Lying	☐	Worries about safety of others	Other:	
☐	Stealing	☐	Always trying to be in control/perfect	Other:	
☐	Peer difficulties	☐	Increase in fears	Other:	

Which behaviors concern you most? Why? _____

_____

_____

_____

Other Life Stressors *Please check the box(es) that apply to your child(ren)/teen(s) and write a brief explanation if applicable.*	
✓	
☐	Divorce or separation:
☐	Incarceration of family member:
☐	Significant illness of self or family member:
☐	Living with disabled family member:
☐	Moving to a new house:
☐	Moving to a new community:
☐	Changing schools:
☐	Friends moving away:
☐	Break up with boyfriend/girlfriend:
☐	Remarriage of parents:
☐	Birth of sibling or addition of new step-sibling:
☐	Parent changing/losing jobs:
☐	Death/illness of pet or pet given away:
☐	Fire or theft loss:
☐	Other *(please explain)*:

Demographic Information

Funding agencies often require nonprofit organizations like the Mourning Hope Grief Center to maintain client information related to gender, race, age, and income level. The requested information is strictly for the purpose of Mourning Hope's compliance with these record-keeping requirements. Responses will remain anonymous, and are greatly appreciated.

Does the child(ren)/teen(s) receive free or reduced lunch at school? ____ No ____ Yes

Household Income: *(circle one)*	Under $20,000	$20,000-$30,000	$30,000-$50,000	$50,000-$100,000	Over $100,000

Racial/ethnic origin of the child(ren)/teen(s): *(circle all that apply)*			
☐ Hispanic/Latinx	☐ Black	☐ White	☐ Asian
☐ Native Hawaiian or Pacific Islander	☐ Indigenous American	☐ Arab	☐ Multi-Racial
Other:			