



Experience a unique therapeutic grief retreat like no other! The Rainbow Retreat is specifically designed for individuals and families of all ages that have experienced the death of a loved one due to a stigmatic death - suicide, homicide, murder, substance abuse, HIV/AIDS, or traumatic death.

The Rainbow Retreat is an innovative grief retreat experience with a twist. Join us at the Tomorrow's Rainbow Ranch for a day filled with tons of healing, understanding and fun. No matter how old you are (yes, grownups too!) or when your grief journey began, the Rainbow Retreat is about unprecedented support and empowerment.

Below is information about the Rainbow Retreat. Don't hesitate to call with additional questions.

Date: 9:00AM – 6:00PM, Saturday, December 15, 2018

Location: Tomorrow's Rainbow, 4341 NW 39th Ave, Coconut Creek, FL 33073

Cost: \$150 per individual, which includes a \$10 registration fee – partial & full scholarships are available.

Activities: Tomorrow's Rainbow is a special place for individuals that have experienced the death of a loved one. By incorporating horse interactions with therapeutic art and play, as well as education on grief and facilitated peer support; children, teens and adults are given the tools necessary to take their own personal grief journey in a way that is meaningful to them. Tomorrow's Rainbow is a safe place where individuals feel, often for the first time, understood.

Meals: Three robust, camp friendly meals are served plus snacks. Any food restrictions or allergies should be communicated directly to our staff one month in advance.

Cell Phones: Adults will be able to have their cell phones during the Rainbow Retreat; however, cell phones will be used for Retreat related phone calls or emergency situations only. Children and teens will not be able to have cell phones for the duration of the Retreat.

Behavior Policy: To maintain a safe environment, street drugs, illicit prescription medications, sniffing glues or compounds, knives, pocket knives, guns or alcoholic beverages are prohibited. Anyone who chooses to bring any of these items, or anything else deemed inappropriate will be asked to leave.

For children, time out discipline will be used for any minor behavioral issues. There will be zero tolerance for misbehavior of any kind. This includes foul language, disrespect of authority and damage or theft of another's belongings.

Personal Property: Tomorrow's Rainbow and the Hopeful TEARS Institute are not responsible for the loss of personal property at the Rainbow Retreat. The Rainbow Retreat is an electronics free experience. Please leave all valuables at home.

Medications: Rainbow Retreat Staff will not be responsible for holding or administering any prescription medications or over-the-counter medications. Special arrangements will be made for certain rescue medications.

Registration: We have space for up to 50 participants. The spaces will be filled on a first come, first served basis and on scholarship availability.

The Enrollment Packet is due by - **November 13, 2018**

Please send completed applications to:
TRainbowMAB@aol.com

Fax#: 561-948-4113

Tomorrow's Rainbow
4341 NW 39th Ave.
Coconut Creek, FL 33073

After the enrollment forms have been submitted and reviewed, you will be contacted two weeks in advance of the Retreat.



Child/Family Enrollment Form

Family Information

Parent/Guardian Name: _____

Address: _____

Cell Phone Number: _____ Home Phone Number: _____

Email Address: _____

Attending Rainbow Retreat Not Attending Rainbow Retreat

Parent/Guardian Name: _____

Address: _____

Cell Phone Number: _____ Home Phone Number: _____

Email Address: _____

Attending Rainbow Retreat Not Attending Rainbow Retreat

Child Name: _____

DOB: _____ Age: _____ Grade: _____ Gender: _____

Child Name: _____

DOB: _____ Age: _____ Grade: _____ Gender: _____

Child Name: _____

DOB: _____ Age: _____ Grade: _____ Gender: _____

Child Name: _____

DOB: _____ Age: _____ Grade: _____ Gender: _____

Name of Deceased Person(s): _____

The deceased person's relationship attendee(s): _____

Cause of Death & Date: _____

Is there anything else you would like us to know?: _____

Please indicate your commitment below:

- I would like to attend and/or send my child(ren) to attend the Rainbow Retreat,
I will pay \$150 per person to attend.
- I am requesting a partial scholarship to attend the Rainbow Retreat,
I will pay \$50 per person to attend.
- I am requesting a full scholarship to attend the Rainbow Retreat,
I will pay the \$10 registration fee per person to attend.

If requesting a partial or full scholarship, please indicate all that apply below:

- My child(ren) qualify for free or reduced school lunch program. Yes No
- Myself or my child(ren) receives Social Security Disability or Food Stamps. Yes No
- Myself or my child(ren) receives Medicare, Medicaid or Florida Healthy Kids. Yes No

I understand that the Hopeful TEARS Institute, Rainbow Retreat & Tomorrow's Rainbow staff have the right to dismiss any participant who is judged detrimental to the welfare of the group or whose conduct is not in accord with the standards of the Hopeful TEARS Institute, Rainbow Retreat & Tomorrow's Rainbow.

As a participant, I agree to assume the full risk and fully release and discharge members of the Hopeful TEARS Institute, Rainbow Retreat & Tomorrow's Rainbow, its directors, officers, trustees, agents, volunteers, employees for any injuries, including death, damages or losses, regardless of severity, which myself or my child(ren) may sustain as a result of any Retreat activity. I agree to waive and relinquish all claims myself or child(ren) have as a result of participating in the Rainbow Retreat through the Hopeful TEARS Institute, its directors, officers, trustees, agents, volunteers and employees as well as to indemnify and hold harmless the aforementioned.

I have fully read and understand the above, and all information supplied by me is accurate and current to the best of my knowledge.

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Health Form

Parent/Guardian Name: _____

Current medical history, including any medications taken: _____

Parent/Guardian Name: _____

Current medical history, including any medications taken: _____

Child Name: _____

Current medical history, including any medications taken: _____

Does your child have a mental health diagnosis (ADHD, anxiety, depression)? _____

Please list any medications your child takes for mental health issues: _____

Child Name: _____

Current medical history, including any medications taken: _____

Does your child have a mental health diagnosis (ADHD, anxiety, depression)? _____

Please list any medications your child takes for mental health issues: _____

Child Name: _____

Current medical history, including any medications taken: _____

Does your child have a mental health diagnosis (ADHD, anxiety, depression)? _____

Please list any medications your child takes for mental health issues: _____

Child Name: _____

Current medical history, including any medications taken: _____

Does your child have a mental health diagnosis (ADHD, anxiety, depression)? _____

Please list any medications your child takes for mental health issues: _____

Authorization for Emergency Medical Treatment

*Please print and complete for each **Adult** attending the Rainbow Retreat*

Adult Name: _____ DOB: _____

Address: _____

Physician's Name: _____ Phone #: _____

Health Insurance Co: _____ Policy #: _____

Allergies to Food, Animals, Etc: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during my participation in programs, or while on the property, I authorize Tomorrow's Rainbow to:

1. Secure and retain medical treatment and transportation if needed; and
2. Release client records upon request to authorized individual or agency involved in the medical emergency treatment.

Consent

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Signature: _____ Date: _____

Non-Consent

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of participating in programs while on the property. In the event emergency treatment/aid is required, I wish the following procedure to take place:

Signature: _____ Date: _____

Authorization for Emergency Medical Treatment

*Please print and complete for each **Child** attending the Rainbow Retreat*

Child's Name: _____ DOB: _____

Address: _____

Physician's Name: _____ Phone #: _____

Health Insurance Co: _____ Policy #: _____

Allergies to Food, Animals, Etc: _____

Allergies to Medications: _____

Current Medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

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In the event emergency medical aid/treatment is required due to illness or injury during the participation in programs, or while on the property, I authorize Tomorrow's Rainbow to:

1. Secure and retain medical treatment and transportation if needed; and
2. Release client records upon request to authorized individual or agency involved in the medical emergency treatment.

Consent

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Signature: _____ Date: _____

Non-Consent

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of participating in programs while on the property. In the event emergency treatment/aid is required, I wish the following procedure to take place:

Signature: _____ Date: _____

Release of Name, Photograph(s) & Personal Information

I hereby grant permission to use my name, my child or ward’s name, personal information, and photograph(s), or other likeness(es) of me, my child or ward, in a WORK presently referred to as “THE WORK.” This may include, but is not limited to, newspaper and magazine articles, advertising materials, and Internet website content to be used for marketing or advertising purposes designed to benefit the mission of Tomorrow’s Rainbow, Inc and/or Hit the Hay, Inc.

The mission of Tomorrow’s Rainbow, Inc., to provide grieving children, teens and their families an emotionally safe environment for hope and healing through guidance, education and support. Said photograph(s) or likeness(es) and personal information are to be used in connection with the advertising and promotion of Tomorrow’s Rainbow, Hopeful TEARS Institute, Rainbow Retreat and “THE WORK” may be published in any and all languages throughout the world.

I also acknowledge that the foregoing rights may be exercised by publishing companies, magazines, newsletters, newspapers, and websites.

Parent/Guardian Name: _____

Parent/Guardian Name: _____

Child Name: _____

Child Name: _____

Child Name: _____

Child Name: _____

Signature of Parent/Guardian: _____

Address: _____

Date: _____

Behavior Agreement

I have read and reviewed the Behavior Policy and am in agreement and in support of the Behavior Policy. I understand the penalty and consequences of not following it.

Signature of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Signature of Child: _____

Signature of Child: _____

Signature of Child: _____

Signature of Child: _____



Hopeful TEARS
INSTITUTE
Teach, Empower & Advocate for Resilience and Success

Bug Bite Medication Authorization

I hereby authorize Tomorrow's Rainbow Hopeful TEARS Rainbow Retreat to administer bug bite medication to my child(ren) as needed after a non-threatening bug bite. The medication used will be Benadryl topical analgesic cream or generic of the same.

I understand that by giving permission to use topical analgesic cream, that my child has no allergies or reactions to the active ingredient: Diphenhydramine hydrochloride & Zinc acetate.

In the event of a serious bug bite, as evidenced by abnormal swelling, pain or other allergic reactions, emergency protocol will be followed.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Guardian's Name: _____

Guardian's Signature: _____

Date: _____

Tomorrow's Rainbow, Inc.
4341 Northwest 39th Avenue, Coconut Creek, FL 33073

WARNING

UNDER FLORIDA LAW, AN EQUINE ACTIVITY SPONSOR, OR EQUINE PROFESSIONAL, IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF, A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES.

RELEASE AND INDEMNITY AGREEMENT

In consideration of the acceptance of my participation and/or the participation of my child or ward, in any equine assisted activity and/or any activity sponsored by Tomorrow's Rainbow, Inc., Hit the Hay, Inc., Berger Counseling Services, Marla Berger and/or Abby J. Mosher, and with the understanding that a horse may be startled by sudden movement, noise or other factors, and may shy suddenly, rear, stop short, bite, buck, kick or run, especially when the program is conducted in a natural setting, as this program is, I AGREE TO ASSUME THE RISKS incidental to such participation including, but not limited to, those risks set out above, and, on my own behalf, on the behalf of my child or ward, and on behalf of my child's or ward's heirs, executors and administrators, RELEASE and forever discharge the released parties defined below, of and from all liabilities, claims, actions, damages, costs or expenses of any nature, arising out of or in any way connected with my participation and/or the participation of my child or ward in such equine program and further agree to indemnify and hold each of the released parties harmless against any and all such liabilities, claims, actions, damages, costs or expenses, including, but not limited to, attorney's fees and disbursements. The released parties are Tomorrow's Rainbow, Inc., Hit the Hay, Inc., Berger Counseling Services, their parent, related, affiliated and subsidiary companies, and the officers, directors, employees, agents, representatives, volunteers, guests, landholders, land owners, successors and assigns of each. I understand that this release and indemnity agreement includes any claims based on the negligence, actions or inaction of any of the above released parties and covers bodily injury and property damage, whether suffered by me, my child or ward before, during or after such participation. I further authorize medical treatment for said child or ward, at my cost, if the need arises.

Child's Name: _____

Child's Name: _____

Child's Name: _____

Child's Name: _____

Guardian's Name: _____

Guardian's Signature: _____

Guardian's Name: _____

Guardian's Signature: _____

Date: _____