Hospice & Palliative Care of Iredell County

Rainbow Kidz

Helping Children & Families Cope With Illness and Grief

Dear Parents,

We are writing to inform you of Rainbow Kidz, a unique pediatric program through Hospice & Palliative Care of Iredell County (HPCIC.) Rainbow Kidz was developed in 2005 to ***improve howchildren,*** ages 6 – 18, ***cope with loss and grief.*** Since children and teens may not possess the skills tocope with serious loss or trauma, their reactions can oftentimes be ***negative, risky and/or serious.*** Tell-tale signs include ***failing grades, attendance issues, negative behaviors at school or home, and strained relationships with family, friends, peers and teachers.*** We offer this program at **NO COST** to children or schools throughout the Iredell County School System.

Rainbow Kidz Grief Support Groups teach participants ***how to cope with the loss of a loved one and gives them tools to deal with future crises.*** These life skills are provided through 10-12 week support groups facilitated by qualified Hospice grief counselors onsite at area schools. These groups last approximately 40 minutes, meet once per week, and will take place during a time which is convenient for your child.

Our goal is to give the students tools to cope with grief in a healthy way and to also improve in other areas if there is an identified need or concern. During the 2016-2017 school year, our grief groups served 440 students in 34 schools. Students Assistance Program Counselors reported that **95% of participating students** improved in at least one of the key indicators of attendance, behavior or grades Students report learning new coping skills to deal with their grief while feeling less isolated as they are educated more about the grief process.

Please initial and sign below to indicate your permission for your child to participate in one of our groups and fill out home address and email so they can be invited to future Rainbow Kidz events. We ask that you also allow us to obtain your child's grades, attendance and behavior information so we can evaluate the effectiveness of the Rainbow Kidz Program.

_____ **Yes, I would like my child to participate in this 10-12 week grief group held at their school.**
Initials

_____ **Yes, I allow Rainbow Kidz to receive my child's school attendance, grades and behavior**
Initials **information from the school counselor. I understand that my child's privacy will be protected. Representatives of Rainbow Kidz and HPCIC will consider this information to be protected health information and will not release it without appropriate authorization. No individual results are shared except when authorized.**

Parent's Signature: _____ **Date:** _____
Address: _____**City:**_____**State**_____**Zip**_____
Email: _____
Child's name: _____

Thank you for your time and consideration. If you should have any questions, please feel free to contact us at 704-924-4313 or visit our website at www.hoic.org and click on Rainbow Kidz.

Best regards,

Leigh Ann Darty, MSW, LCSW
LCSW Director of Rainbow Kidz

Shelly Luttman, MSW
Rainbow Kidz, Grief Counselor

[redacted]

AUTHORIZATION FOR USE AND DISCLOSURE OF IMAGE, VOICE AND/OR WRITTEN TESTIMONIALS

Please review the following information prior to signing on the Permission page:

Type of information to be released: Video images, photographic images, conversations, sounds, and audiotapes of individuals or groups as they participate in HPCIC sponsored events. This consent will also include verbal and/or written testimonials and statements, including biographical information and protected health information of the individual identified above.

Purpose of request: To videotape, photograph and record audio of patients or participants in programs offered or coordinated by HPCIC. These videotapes, photographs and audio recordings may be used for marketing purposes, including but not limited to production of recordings, brochures, advertisements, internet stories, social media, videos and similar image and sound capture for purposes of publication and/or distribution via all types of media.

Persons authorized to receive information: I agree that the publication and distribution of the personal or protected health information described herein may and likely will include distribution of such information to the general public via various methods, including all types of media outlets (e.g., TV, radio, newspaper, internet) for HPCIC's marketing purposes. I also understand HPCIC may hire third parties to capture the image and/or voice recording of the individual identified above, and that any information will be used and disclosed by these third parties as instructed by the organization.

Expiration and right to revoke Authorization: Except to the extent that action has already been taken in reliance on this Authorization, at any time I can revoke by submitting a notice in writing to the HPCIC's Compliance Officer at 2347 Simonton Road, Statesville, NC, 28625.

Re-disclosure: I understand that the information disclosed by this Authorization may be subject to re-disclosure by anyone receiving it, and the information disclosed will no longer be protected by the Health Information Portability and Accountability Act of 1996 (HIPAA). HPCIC's employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By signing below, I grant permission for HPCIC to photograph/video/interview my child or use my child's artwork for educational purposes or to promote the Rainbow Kidz Program of Hospice & Palliative Care of Iredell County. I signify that I have read the Authorization for use and Disclosure of Image, Voice and/or written testimonials, and agree to terms and conditions listed therein. This Authorization applies to protected information created during the current school year.

Parent's Signature: _____Date: _____