Dear Parents,

The Arc of Caddo-Bossier is excited to offer Camp Victory for the 13th summer in a row. Camp Victory is an inclusive summer camp program for children with special needs and their typically developing peers and siblings, ages 4-10. The camp will be held at GREAT's beautiful facility (7141 Greenwood-Spingridge Road) in Greenwood, LA. The children will participate in activities such as horseback riding, sports, arts and crafts, science and nature studies, falconry and gardening.

Camp Victory will be held the first 2 full weeks in June with 36 children attending each week. The fee for all campers is $125.00 which helps cover registration, food and supplies. The campers arrive at GREAT at 8:45 a.m., and activities begin at 9:00 a.m. We will divide the campers into 3 different groups and participate in 3 different activities. Campers will need to be picked up at GREAT at 12:30 p.m. Mid-morning snacks and lunch will be provided for campers along with lots of water and juice throughout the morning activities.

The Arc of Caddo-Bossier is excited to offer Camp Victory because we feel there is a need in the community for summer recreational opportunities for school aged children with special needs and their siblings and peers. We will be collaborating with other non-profit organizations to include a variety of activities and their volunteers. On Friday, the end of each camp session, parents, grandparents, and other family members and friends are invited to Camp Victory for a picnic and horse show (put on by the campers). Camp Victory has very limited availability and applications are accepted on a first come, first serve basis. Please return the **complete** application and payment by May 12, 2017 (Only a completed application and payment will hold your spot) and I will then send you a follow up information packet. Feel free to contact me at 318-938-9166 if you have any questions. The staff at GREAT and The Arc Caddo-Bossier looks forward to working with you and your children in a wonderful summer recreational opportunity.

Sincerely,

Caroline Hendrix
Director of GREAT

* Pages 1-4 are to be filled out by the parents/guardian. Page 5 is to be filled out and signed by your child's physician, this is for all children. Please complete every question on the application and return the original application.

Camp Victory

Application Form

Return COMPLETE application by May 12, 2017 to:

GREAT
7141 Greenwood-Springridge Rd.
Greenwood, LA 71033
(318) 938-9166

**********MAKE CHECK PAYABLE TO: THE ARC CADDO-BOSSIER**********

Week applying for: ______1st session June 5-9, 2017 ~ 9:00 am- 12:30 pm **OR**
______2nd session June 12-16, 2017 ~ 9:00 am-12:30 pm

PERSONAL INFORMATION (To be filled out by parent or guardian):

Name____
Last First Likes to be called

Address____
Street City State Zip

Phone number ( )_____-________ Email ________________________DOB____________

Age_________ Sex M F Height________ Weight________ T-shirt size_______
(S 6-8, M 10-12, or L 14-16)

Father's name__________________________________ Phone #____________
Last First

Mother's name__________________________________ Phone #____________
Last First

Are you enrolling your child as a:
______child with special needs **OR**
______typically developing sibling/peer

CAMPER INFORMATION: (please put N/A if not applicable)

What are your child's interests and hobbies?______________________________________

____

What is the extent of your child's disability?______________________________________

____

____

Does your child take any medications regularly between 8:00 a.m. and 1:00 p.m.?

____

How does your child communicate?_____verbal _____non-verbal _____sign language
_____augmentative communication device

Does your child use any adaptive equipment? _____wheelchair _____crutches
_____braces _____walker _____other (please list)________________________________

Is there a limitation on how long they can be in this equipment?_________________

____

Does your child have any dietary restrictions or food and drink allergies?

____

Please describe any special dietary needs your child has. _______________________

____

Is your child allergic to _____insect stings? _____poison ivy? _____ant bites?

_____other? (please list) ____

Describe reaction to allergies____

____

Does your child need assistance with toileting?___________________________________

____

Does your child have any known fears (i.e. spiders, animals, lightning, thunder)?

____

What works well to comfort your child?____

____

Does your child have any restrictions from activities, please explain? ____________

____

Please include anything you feel may be important for our staff to better know your child (i.e. social, medical, behavioral, etc.).______________________________________

____

____

EMERGENCY CONTACT INFORMATION:
In case of an emergency please contact:

____ **OR**
Name hm phone # wk phone #

____
Name hm phone # wk phone #

CONSENT:

I hereby give my consent for my child, ____, to attend Camp Victory and participate in all activities. In consideration for the acceptance of the above named, I hereby release and waive any and all claim or cause of action for negligence which may accrue against Camp Victory or any employee of either one, and any other person acting with the permission of either arising out of any injury and/or loss to the person or property of such child during his/her stay at the camp, in transit to and from the camp; or during any activity approved by any said persons, and I agree to assume all liability for any claims which said child in his/her personal capacity might have against any said persons for injury as herein stated.

____ ______________

Signature (Parent or Guardian) Date

PHOTO RELEASE

I hereby consent to and authorize the use and reproduction by Camp Victory and GREAT (Great Results Equine Assisted Therapies) of any and all photographs and any other audiovisual materials taken of my son/daughter for promotional printed material, educational activities or for any other use for the benefit of the programs.

____ ______________

Signature (Parent or Guardian) Date

LIABILITY RELEASE

_________________________________(Camper's Name) would like to participate in the Camp Victory and GREAT (Great Results Equine Assisted Therapies) programs. I acknowledge the risks and potential for risks of activities and horseback riding. However, I feel that the possible benefits to my son/daughter are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators waive and release forever all claims for negligence and damages against Camp Victory and GREAT, their Board of Directors, Instructors, Counselors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses my son/daughter may sustain while participating in Camp Victory and GREAT.

____ ______________

Signature (Parent or Guardian) Date

PAYMENT: The fee for all children is $125.00. Checks should be made payable to The Arc of Caddo-Bossier. Please note in the memo field "Camp Victory".

GREAT

RIDER'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize GREAT RESULTS EQUINE ASSISTED THERAPIES to:

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

Client's Name:____Phone____________

Address:____

In the event I cannot be reached, Contact:____________________ Phone:_________________

Contact:____________________ Phone:_________________

Physician's Name:____

Preferred Medical Facility:____

Health Insurance Co:____________________________________ Policy #:______________

Consent Plan

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 below is unable to be reached.

Date:____________________Consent Signature:_______________________________________

Client, Parent, or Guardian

Print Name:____Phone:_________________

Address:____

Non-Consent Plan

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

____

____

Date:____________________ Non-Consent Signature:_________________________________

Client, Parent, or Guardian

Print Name:____ Phone:_________________

Address:____

RIDER'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT
TO BE COMPLETED ANNUALLY AND ORIGINAL RETURNED TO GREAT

Name:____ Date of Birth:____________

Address:____

Name of Parent/Guardian:____

Diagnosis:____ Date of onset:____________

*****FOR PERSONS WITH DOWN SYNDROME (MINIMUM AGE: 3 YEARS OLD) (BOTH ITEMS BELOW MUST BE CHECKED BY PHYSICIAN AND X-RAY DATE PROVIDED, OR STUDENT WILL NO T BE ABLE TO PARTICIPATE)***

________ Negative Cervical X-ray for Atlantoaxial Instability. X-ray Date:______________ (Every 3 Years)

________ Negative for clinical symptoms of Atlantoaxial Instability.

Tetnus Shot: ___Yes ___No Date:______________ Height:____________ Weight:__________

Seizure Type:__________________ Controlled: ______________ Date of Last Seizure:__________

Medications:____

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation: ___Yes ___No Crutches: ___Yes ___No Braces: ___Yes ___No

Wheelchair: ___Yes ___No Please indicate any special precautions: ________

____

____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print):____

Physician Signature:____

Address:_______________________City_______________State__________Zip__________

Phone:__________________________ Date:______________

ATTENTION: Physician, Please See Other Side →

INFORMATION FOR PHYSICIAN

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Heterotopic Ossification
Osteogenesis Imperfecta
Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

MEDICAL/SURGICAL

Allergies
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition
Stroke (Cerebrovascular Accident)

NEUROLOGIC

Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis Due To Spinal Cord Injury
Seizure Disorders

SECONDARY CONCERNS

Behavior problems
Age under two (2) years
Age two (2) to four (4) years
Acute Exacerbation or chronic disorder
Indwelling Catheter