Dear Parents,

The Arc Caddo Bossier's GREAT program is excited to offer Camp Victory for the 21st 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 is held at GREAT's beautiful facility (7141 Greenwood-Spingridge Road) in Greenwood, LA. The children will participate in activities such as horseback riding, team building, arts and crafts, science and nature studies and falconry.

Camp Victory will be June 5-9 and June 12-16 with 36 children attending each week. The fee for all campers is $125.00 and there is a $15.00 registration fee due with the completed application to secure your spot at camp. The campers arrive at GREAT at 8:50 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 daily. Campers are picked up promptly at GREAT at 12:30 p.m. Mid-morning snacks are provided for campers along with lots of water and throughout the morning activities. **Please bring your own lunch Monday-Thursday** and join us for a hotdog cookout and horseshow on Friday.

We will be collaborating with other non-profit organizations to include a variety of activities. Camp Victory has very limited availability and applications are accepted on a first come, first serve basis. Please return the **complete** application and $15 registration fee by May 5, 2023 (Only a completed application and registration fee 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 and volunteers at GREAT look forward to working with you and your children in a wonderful summer recreational opportunity.

Sincerely,

Liz Thigpen
Camp Director

* 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 5, 2023 to:

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

**********MAKE CHECK PAYABLE TO: THE ARC CADDO-BOSSIER**********
**********BRING LUNCH MONDAY-THURSDAY**********

_____camp session June 5-9, 2023 ~ 9:00 am- 12:30 pm
_____camp session June 12-16, 2023 ~ 9:00-12:30 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 12:30 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/The Arc Caddo Bossier's GREAT program 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 The Arc Caddo Bossier's GREAT program 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 The Arc Caddo Bossier's GREAT program. 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 The Arc Caddo Bossier's GREAT program, 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 The Arc Caddo Bossier's GREAT program.

_____ _____

Signature (Parent or Guardian) Date

PAYMENT: Registration Fee of $15.00 due with application to hold your spot, $125.00 due by the first day of camp. Checks should be made payable to The Arc Caddo-Bossier. Please note "Camp Victory" in the memo field.

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 The Arc Caddo Bossier's GREAT program 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 NOT BE ABLE TO PARTICIPATE)***

_____ Negative Cervical X-ray for Atlantoaxial Instability. X-ray Date:_____

_____ 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