



(Fishing, Arts-n-Crafts, and Equestrian Skills)

Return form to above address. Please answer all questions completely, as this information will be used to provide a safe and enjoyable experience for the applicant.

Note: If your child is unable to sit astride a horse due to contraindications, other horse related activities can be provided.

IDENTIFICATION	Age _____	Sex F M	
Applicant's Name _____ Date of Birth _____			
Address _____ City _____ State _____ Zip _____			
Guardian's Name _____ Relationship _____			
Phone _____ Cell/pager _____ Work _____			
ALTERNATE EMERGENCY CONTACT: (other than guardian listed above)			
Name _____ Relationship _____			
Phone _____ Cell/pager _____ Work _____			
SCHOOL INFORMATION			
School attends _____ Grade _____			
HEALTH INFORMATION (This information is only in case of an emergency)			
Health/Accident Insurance _____ Policy No. _____			
Group No. _____ Medicaid No. _____			
*Please attach a copy of insurance/medicaid cards.			
Primary Physician _____ Phone _____			
Address _____			
Nature of Disability			
Does the applicant have a disability: YES NO			
If yes, then please check all that apply:			
<input type="checkbox"/> Amputee	<input type="checkbox"/> Multiple Sclerosis	Mental Ability: (check one) <input type="checkbox"/> Normal function <input type="checkbox"/> Learning disabled <input type="checkbox"/> Mildly MR <input type="checkbox"/> Moderately MR <input type="checkbox"/> Severely MR <input type="checkbox"/> Profoundly MR	
<input type="checkbox"/> Autism	<input type="checkbox"/> Developmental Delay		
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Muscular Dystrophy		
<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Down Syndrome		
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Speech Impairment		
<input type="checkbox"/> Visual Deficits	<input type="checkbox"/> Hearing Impairment		
<input type="checkbox"/> Brain Damage			
<input type="checkbox"/> Other disability: _____			
Allergies: Food, medicines, insects, plants- YES <input type="checkbox"/> NO <input type="checkbox"/>			
Explain: _____			
List any physical or behavioral conditions that may affect or limit full participation in fishing, horseback riding, and/or vigorous group games: _____			
Applicant's Name: _____			
Check all items that apply, past or present , to applicant's health history. If YES , explain.			

General:	YES	NO		YES	NO		YES	NO
Shunt	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizure	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Contractures	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Contacts/glasses	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis/Kyphosis	<input type="checkbox"/>	<input type="checkbox"/>	Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Explain: _____								
Please list ALL medications: _____								
List any medications to be taken at camp: _____								
Summarize applicant's operations/surgeries or serious injuries with dates: _____								
Immunizations: (Give date of last inoculation)								
Tetanus toxoid _____			Measles _____			Polio _____		
Diphtheria _____			Mumps _____			Pertusis _____		
Chicken Pox _____			Rubella _____			_____		
Mobility	<input type="checkbox"/> walks alone <input type="checkbox"/> walker/crutches <input type="checkbox"/> electric wheelchair <input type="checkbox"/> manual wheelchair Can applicant move by self? Yes No							
Transfers	<input type="checkbox"/> no assistance <input type="checkbox"/> needs assistance How much? _____ Can applicant bear weight when standing? Yes No							
Sitting (example edge of bed)	<input type="checkbox"/> no assistance <input type="checkbox"/> needs assistance How much? _____ Sitting tolerance: <input type="checkbox"/> 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> over 60 min							
Assistive Devices	<input type="checkbox"/> none <input type="checkbox"/> helmet <input type="checkbox"/> braces <input type="checkbox"/> prosthesis <input type="checkbox"/> oxygen <input type="checkbox"/> glasses <input type="checkbox"/> hearing aid <input type="checkbox"/> wheelchair <input type="checkbox"/> other _____							
Communication	Does applicant have difficulty expressing thoughts or wants? Yes No Does applicant use: <input type="checkbox"/> communication board <input type="checkbox"/> computer <input type="checkbox"/> gestures <input type="checkbox"/> sign language <input type="checkbox"/> other _____							
Eating	<input type="checkbox"/> no assistance <input type="checkbox"/> partial assistance <input type="checkbox"/> total assistance <input type="checkbox"/> special utensils: _____							
Diet	<input type="checkbox"/> normal <input type="checkbox"/> chopped food <input type="checkbox"/> blended/pureed <input type="checkbox"/> low calorie <input type="checkbox"/> low salt <input type="checkbox"/> diabetic <input type="checkbox"/> peg tube <input type="checkbox"/> food allergies _____ <input type="checkbox"/> special diet (<i>please attach specifics on separate paper; not all special diets can be met at camp you may however pack your child's snack if needed</i>)							
Bowel Control	<input type="checkbox"/> always <input type="checkbox"/> sometimes <input type="checkbox"/> needs reminders <input type="checkbox"/> incontinent <input type="checkbox"/> needs assistance <input type="checkbox"/> on schedule: _____							
Bladder Control	<input type="checkbox"/> always <input type="checkbox"/> sometimes <input type="checkbox"/> needs reminders <input type="checkbox"/> incontinent <input type="checkbox"/> needs assistance <input type="checkbox"/> on schedule: _____							
Aids Used (bring to camp if appropriate)	<input type="checkbox"/> catheter (type: _____) <input type="checkbox"/> urinal <input type="checkbox"/> special toileting chair <input type="checkbox"/> diapers/special undergarment <input type="checkbox"/> other: _____							

Applicant's T-shirt size: _____

Where did you hear about our camp? _____

Medical Evaluation and Referral

Return form to above address.

NOTE TO LICENSED HEALTH-CARE PRACTITIONER: The applicant/person being evaluated will be attending a one-week camp that may include participating in strenuous activities such as horseback riding, fishing, and vigorous group games. The camp is ~ 4 hours long each day for 5 days. Safety equipment and specially trained horses, medical personnel, and volunteers will be used. In order to assure the fullest possible protection and greatest personal benefit from the camp, each applicant is required to furnish the following medical information before being accepted.

NOTE: BECAUSE OF THE NATURE OF THE ACTIVITY OF HORSEBACK RIDING, NO INDIVIDUAL DIAGNOSED DOWN'S SYNDROME CAN BE ACCEPTED FOR RIDING INSTRUCTION WITHOUT PROOF OF A NEGATIVE DIAGNOSTIC X-RAY FOR ATLANTOAXIAL DISLOCATION CONDITION.

Name: _____ Date of Birth: _____

PHYSICAL EXAMINATION (To be filled out by a licensed physician)

Diagnosis: _____ Date of Onset: _____

IF THE DIAGNOSIS IS DOWN'S SYNDROME, THIS FORM MUST BE ACCOMPANIED BY: a signed, dated statement from a qualified physician giving the date and result of a diagnostic X-ray for Atlantoaxial Dislocation Condition.

Height: _____
Weight: _____
B/P: _____/_____
Pulse: _____

VISION:
 Normal
 Glasses
 Contacts

HEARING:
 Normal
 Abnormal
Explain: _____

Check box:	N	Abn		N	Abn		N	Abn
Growth development	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Cardiopulmonary system	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Neurobehavioral	<input type="checkbox"/>	<input type="checkbox"/>
Coordination	<input type="checkbox"/>	<input type="checkbox"/>	Sight	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>
Neuro-sensation	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Tone	<input type="checkbox"/>	<input type="checkbox"/>

Explain if abnormal: _____

Diet Restrictions: _____

Surgical Procedures: _____

Medications: _____

Medical History: _____

Recommendations (explain any restrictions OR limitations): _____

IN MY OPINION THE PATIENT NAMED MAY ATTEND THE CAMP AND RECEIVE RIDING INSTRUCTION UNDER APPROPRIATE SUPERVISION.

Physician's Signature

Date

Address

Phone

West Calcasieu Cameron Hospital's
Therapeutic Riding Center
886 Landry Lane
Sulphur, Louisiana 70663

Ph: (337) 625-3972
Fax: (337) 625-5722



(Fishing, Arts-n-Crafts, and Equestrian Skills)

RELEASE FORM

Liability Release

_____ (Applicant's name) would like to participate in Camp Smiling FACES at West Calcasieu Cameron Hospital's Therapeutic Riding Center. I acknowledge the risks and potential for risks of horseback riding, fishing, and vigorous group games. However, I feel that the possible benefits to myself/my son/my daughter/my ward 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 damages against West Calcasieu Cameron Hospital's Therapeutic Riding Center, its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Camp Smiling FACES. Applicant has my permission to engage in all camp activities, including transportation as deemed necessary, except as noted in writing by the physician or myself.

Applicant, Parent, or Guardian

Date

Photo Release

I hereby consent to and authorize the use and reproduction by West Calcasieu Cameron Hospital's Therapeutic Riding Center and Camp Smiling FACES of any and all photographs and any other audiovisual materials taken of myself/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Applicant, Parent, or Guardian

Date

Emergency Medical Treatment

CONSENT PLAN

This authorizes West Calcasieu Cameron Hospital to secure and retain medical treatment and transportation if needed due to illness or injury during the process of participation at camp, or while being on the property of West Calcasieu Cameron Hospital. 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.

Applicant, Parent, or Guardian

Date

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in case of illness or injury during the process of participation at camp or while being on the property of West Calcasieu Cameron Hospital. In the event emergency treatment/aid is required, I wish the following procedures to take place: _____

Applicant, Parent, or Guardian

Date

Camp Smiling F.A.C.E.S.

Important Notice to Parents/Guardians

Application Process:

Complete and return the following forms:

- 1) Camper Application form (2 pages)
- 2) Medical Form (completed and signed **by licensed physician only, not by parent/guardian**)
- 3) Release Form
- 4) Copy of insurance card (Front and Back)
- 5) Copy of specific diet (if applicable)
- 6) Pick up Form
- 7) Fee cost \$75.00 (if you have multiple children please call (337) 625-3972)

Eligibility:

All acceptances are conditional! Camp Smiling F.A.C.E.S. has the right and obligation to send a camper home due to health, medical, or behavioral reasons. Predicting the camper's reaction to the camp experience may be difficult, therefore, parents or guardians must be accessible at all times during the camp session.

Initial consideration for acceptance is a special needs child between the ages of 4 and 12 years old. This may include, but is not limited to, autism, amputee, epilepsy, spina bifida, cerebral palsy, visual deficits, brain damage, developmental delay, muscular dystrophy, down syndrome, speech/hearing impairment, and other disabilities. This does not include emotional or behavioral problems. Inappropriate behavior may include hitting, kicking, biting, hair pulling, inappropriate sexual behavior, or swearing exhibited toward other campers or staff/volunteers. This type of behavior is a safety issue and takes away from the purpose of the camp experience. Additional factors regarding acceptance may be medically based such as against physician's recommendation, continuous tube feeding, etc. Snacks will be provided, but if your child is on a special diet, you may need to furnish the appropriate foods.

Safety Guidelines for Camp Participation:

In order to insure a safe and positive camp experience for all campers, staff, and volunteers, each camper must meet the following guidelines to be eligible to participate:

- Does not have a history of or demonstrate excessive verbal abuse.
- Does not have a history of or demonstrate physical aggression (i.e. hitting, kicking, spitting, biting, scratching).
- Does not have a history of or demonstrate inappropriate sexual behavior (i.e. sexual touch or comments towards others or self).
- Does not have a history of or demonstrate uncontrolled grand mal seizures
- Does not have a history of or demonstrate any behaviors that may place campers, staff, or volunteers at risk.
- Able to participate safely in a small group setting. If more supervision is needed, the parent/guardian may be required to provide an aide (paraprofessional).

Deadlines

Friday May 28, 2010 NO EXCEPTIONS – application

(due to number of staff the first 30 approved applications will be excepted only)

Please Mail or Drop off Original Documents to: WCCH Therapeutic Riding Center
886 Landry Lane Sulphur, LA 70665

West Calcasieu Cameron Hospital's
Therapeutic Riding Center
886 Landry Lane
Sulphur, Louisiana 70663



Ph: (337) 625-3972
Fax: (337) 625-5722

(Fishing, Arts-n-Crafts, and Equestrian Skills)

Pick up Form

Please fill out the information regarding individuals who will be picking up your child from Camp Smiling F.A.C.E.S 2010. All drivers must be prepared to show us their driver's license for proof of identification. If you need to use a driver not on your original list, you must call and leave a message, providing camper's name, name of person picking up camper, and their driver's license number.

Camper: _____

My child may be picked up by:

Name _____ **Relation** _____
Driver's License Number _____ **State** _____
Phone _____ **Cell/pager** _____ **Work** _____

Name _____ **Relation** _____
Driver's License Number _____ **State** _____
Phone _____ **Cell/pager** _____ **Work** _____

Name _____ **Relation** _____
Driver's License Number _____ **State** _____
Phone _____ **Cell/pager** _____ **Work** _____

Parent's Signature _____ **Date** _____