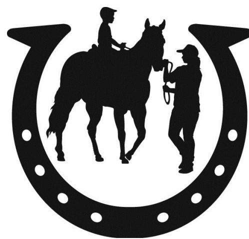
West Calcasieu Cameron Hospital
Therapeutic Riding Center
886 Landry Lane
Sulphur, Louisiana 70663

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



CAMP SMILING F.A.C.E.S
(**F**ishing, **A**rts-n-**C**rafts, and **E**questrian **S**kills)

Camper Cover Letter

Dear Parents/Guardians,

Camp Smiling F.A.C.E.S. **2025** will be held **6/02/25 – 6/05/25** from **8:00 a.m. - 11:00 a.m**. each day. The cost of the camp is **$65.00** per child and will cover the costs associated with the camp's various activities. Activities include horseback riding, fishing, socialization, and arts-n-crafts. Due to many campers having a limited diet or dietary restrictions, we are requesting that parents provide a small snack each day for their camper.

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, downs syndrome, speech/hearing impairment, and other disabilities. For the safety of the horses and staff we have a **120 lb** weight limit to ride. If your child requires a specialized helmet, hearing aids, medications, special equipment, insect repellent, sun screen, or any other item, please be sure to send those items with them to camp along with instructions.

Parents may begin dropping off campers at 7:30 a.m. Please line up in a single file line on the road and follow instructions from staff and volunteers. Please do not get out of your vehicle. Campers are to be picked up at 11 a.m. each day in the same manner. Please, no early birds. In addition, anyone picking up a child MUST be listed on the pick-up form and have a form of identification.

AS HORSEBACK RIDING IS PART OF THE CAMP, **CLOSED TOE SHOES ARE REQUIRED**. **ANYONE WEARING FLIP FLOPS OR SLIP ON SHOES WILL NOT BE ALLOWED IN THE BARN AREA**. **ALSO, SHORTS ARE TO BE WORN UNDER ALL SKIRTS.**

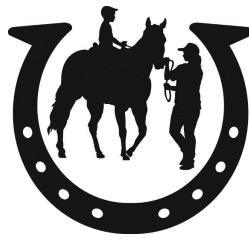
Limited space is available. All applications must be received by April 29, 2025 and are taken on a first come first serve basis. Checks should be made payable to West Calcasieu Cameron Hospital, with Camp Smiling F.A.C.E.S. in the memo. Please mail or drop off the original documents and fees to:

WCCH Genesis Therapeutic Riding Center
Camp Smiling F.A.C.E.S.
886 Landry Lane
Sulphur, LA 70663

If you have any questions, please call the Genesis Therapeutic Riding Center at (337) 625-3972.

Sincerely,
Genesis Therapeutic Riding Center Staff

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



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Important Notice to Parents/Guardians

Application Process:

Complete and return the following forms:

1) Camper Application form (3 pages)
2) Medical Form (completed and signed **by licensed physician only, not by parent/guardian**)
3) Release Form (liability, photo, and emergency medical treatment)
4) Camper pick-up Form
5) Copy of insurance card (Front and Back)
6) Copy of specific diet (if applicable)
7) $65.00 Camp Fee

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's 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 and will not be tolerated. For the safety of our horses and staff there is a weight limit of 120 lbs. to ride the horses.

Additional factors regarding acceptance may be medically based such as, it being against physician's recommendation, continuous tube feeding, etc. Due to many campers having a limited diet or dietary restrictions, we are requesting that parents provide a small snack each day for their camper.

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/shadow).

Deadlines

Tuesday, April 29, 2025 NO EXCEPTIONS – application
(applications will be considered on a first come first serve basis due to limited spots available)

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

West Calcasieu Cameron Hospital
Therapeutic Riding Center
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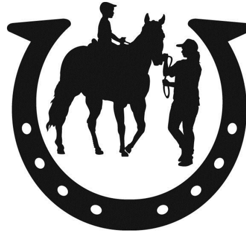

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Return form to above address. Please answer all questions completely, as this information will be used to provide a safe and enjoyable experience for the applicant.

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

IDENTIFICATION:
Child's Name____ Date of Birth _______________
Weight _____________ Age ____________ Sex **F** **M**
Address____
City_____________________________________ State_____________ Zip _____________

Parent/Guardian's Name ____
Relationship____________________________ Phone__________________________________

ALTERNATE EMERGENCY CONTACT: *(other than guardian listed above)*
Name ____ Relationship________________
Phone_____________________________

SCHOOL INFORMATION
School attends ____Grade________________

HEALTH INFORMATION (This information is only in case of an emergency)
Medical 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:

Amputee
Autism
Epilepsy
Spina Bifida
Cerebral Palsy
Visual Deficits
Brain Damage
Multiple Sclerosis
Developmental Delay
Muscular Dystrophy
Down Syndrome
Speech Impairment
Hearing Impairment
Other disability: ________________________________

Cognitive Ability: (*check one*)
Normal function
Learning disabled
Mild ID
Moderate ID
Severe ID
Profoundly ID

Allergies: Food, medicines, insects, plants- **YES** **NO**
Explain:____

OFFICE USE ONLY:
Date Rec'd________________ Date approved________________ Amt. Fee rec'd______________ Date Rec'd_______________
Confirmed by ___*Phone* ___*Letter* ___ *In person* Declined secondary to ____
Note: ____

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List any physical or behavioral conditions that may affect or limit full participation in fishing, horseback riding, and/or vigorous group games: ____

____

Child'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			Convulsions/Seizure			Hemophilia		
Asthma			Diabetes			High Blood Pressure		
Contractures			Heart Trouble			Fainting spells		
Contacts/glasses			Scoliosis/Kyphosis			Deformity		

Explain: ____

Please list **ALL** medications child is currently taking: ____

____

List any medications to be taken at camp: ____

Summarize child's operations/surgeries or serious injuries with dates: __________________________

____

Immunizations: (Give date of last vaccination or attach a current vaccination record)

Tetanus toxoid	_______________	Measles	_______________	Polio	_______________
Diphtheria	_______________	Mumps	_______________	Pertusis	_______________
Chicken Pox	_______________	Rubella	_______________		_______________

Mobility	walks alone walker/crutches electric wheelchair manual wheelchair Can applicant move by self? **Yes** **No**
Transfers	no assistance needs assistance How much?_______________ Can applicant bear weight when standing? **Yes** **No**
Sitting (example edge of bed)	no assistance needs assistance How much?_______________ Sitting tolerance: 15 min 30 min over 60 min
Assistive Devices	none helmet braces prosthesis oxygen glasses hearing aid wheelchair other_______________
Communication	Does applicant have difficulty expressing thoughts or wants? **Yes** **No** Does applicant use: communication board computer gestures sign language other_______________
Eating	no assistance partial assistance total assistance special utensils: _______________
Diet	normal chopped food blended/pureed low calorie low salt diabetic peg tube food allergies_______________ special diet _______________
Bowel Control	always sometimes needs reminders incontinent needs assistance on schedule:_______________
Bladder Control	always sometimes needs reminders incontinent needs assistance on schedule:_______________
Aids Used (bring to camp if appropriate)	catheter (type:_______________) urinal special toileting chair diapers/special undergarment other:_______________

OFFICE USE ONLY:

Date Rec'd_______________ Date approved_______________ Amt. Fee rec'd_______________ Date Rec'd_______________

Confirmed by ___*Phone* ___*Letter* ___ *In person* Declined secondary to _______________________________

Note: ____

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Additional information that you feel we need to know may be written below:

OFFICE USE ONLY:
Date Rec'd_______________ Date approved_______________ Amt. Fee rec'd______________ Date Rec'd______________
Confirmed by ___*Phone* ___*Letter* ___ *In person* Declined secondary to ____
Note: ____

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Medical Evaluation and Referral

Return form to above address or fax 337-625-5722

NOTE TO LICENSED HEALTH-CARE PRACTITIONER: The applicant/person being evaluated will be attending a 4 day camp that may include participating in strenuous activities such as horseback riding, fishing, and vigorous group games. The camp is ~ 3 hours long each day for 4 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 WITH 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.

	VISION:	HEARING:
Height: ___________	Normal	Normal
Weight:___________	Glasses	Abnormal
B/P: ______/______	Contacts	Explain:____________
Pulse: ___________		

Check box:	N	Abn		N	Abn		N	Abn
Growth development			Teeth			Genitalia		
Cardiopulmonary system			Skin			Musculoskeletal		
HEENT			Hernia			Neurobehavioral		
Coordination			Sight			Mobility		
Neuro-sensation			Seizures			Muscle Tone		

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

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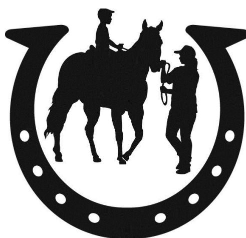

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RELEASE FORM

Liability Release

________________________________(Applicant's name) would like to participate in Camp Smiling F.A.C.E.S at Genesis Therapeutic Riding Center of West Calcasieu Cameron Hospital. 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 Genesis Therapeutic Riding Center of West Calcasieu Cameron Hospital and West Calcasieu Cameron Hospital, 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 F.A.C.E.S. 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, the undersigned, do hereby consent and agree that West Calcasieu Cameron Hospital, its employees, agents, and the press may take photographs, videotape, or digital recordings of me/my son/my daughter/my ward and to use these in any and all media, now or hereafter known, and exclusively for the marketing purposes of the agency. I further consent that my/my son's/my daughter's/my ward's name and identity may be revealed therein or by descriptive text or commentary.
I do hereby release to West Calcasieu Cameron Hospital, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my/my son's/my daughter's/my ward's identity or likeness in whatever media used.
I understand that I will not be paid for my/my son's/my daughter's/my ward's photograph/recording, either for initial or subsequent transmission or playback. I also understand that West Calcasieu Cameron Hospital is not responsible for any expense or liability incurred as a result of my/my son's/my daughter's/my ward's participation in the recording, including medical expenses due to any sickness or injury incurred as a result.
I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute the agreement.

________________________________ ________________
Applicant, Parent, or Guardian Date

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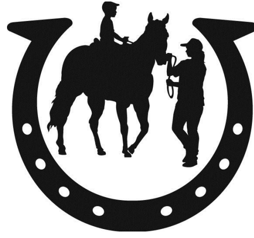

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Emergency Medical Treatment Consent Plan
This authorizes West Calcasieu Cameron Hospital to secure and retain medical treatment and transportation if needed due to illness or injury during the process of participation at camp, or while being on the property of Genesis Therapeutic Riding Center 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 the Genesis Therapeutic Riding Center 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

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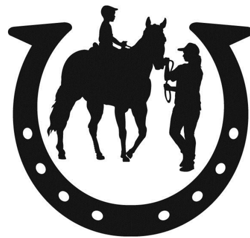

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Camper Pick up Form

Please fill out **ALL** the information regarding individuals who will be picking up your child from Camp Smiling F.A.C.E.S. 2025. 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 __________________

Name___________________________________ Relation______________________
Driver's License Number ____________________________ State____________
Phone___________________ Cell __________________

Name___________________________________ Relation______________________
Driver's License Number ____________________________ State____________
Phone___________________ Cell __________________

Parent's Signature_________________________________ **Date**______________