Thank you for your interest in CampAbility which will be located at Hilltop Developmental Preschool: 1915 E. 86th Street Indianapolis, IN 46240. We are excited that you and your family are considering sending your loved one to spend time with us this summer!

CampAbility is a traditional, non-academic, day camp designed to serve families of children who present with a primary disability such as cerebral palsy, spina bifida, down syndrome, autism, developmental delays, etc. Should you have questions regarding eligibility for this camp, please contact us.

Below you will find a list of the registration forms (mandatory and supplemental) that must be completed in order for your child to attend CampAbility. These forms must be thoroughly completed and submitted with all supporting documents and the camp deposit in order to secure a spot for camp. Your spot will not be confirmed until we have all necessary documents and information. ***Registration forms are due April 28, 2017***

We have a lot of fun activities planned including field trips, therapeutic horseback riding, special guest visitors and much, much more! We can't wait to hear from you! ☺

☐ **MANDATORY FORMS:**

☐ **SUPPLEMENTAL FORMS:**

For questions regarding camp or to submit payment and registration forms, please contact:

Easterseals Crossroads, Attn: Karen Kelley
4740 Kingsway Drive
Indianapolis, IN 46205
Phone: 317.466.1000 | Fax: 317.466.2000 | Email: kkelley@eastersealscrossroads.org

Reservation and Payment Information

Participant Name: _____ Date:_____

Cost: CampAbility costs $300 per session ($199 early bird special if registration is received between January 16 and February 28 2017.

To reserve a spot at CampAbility you must include the following:

- A **$100** deposit **per camp session** (the deposit is refundable if cancellation occurs two weeks or more prior to the session start date).
- All completed registration forms with doctors signatures (where needed)
- Support plans

Please indicate below which camp you would like the participant to attend and which sessions:

☐ CampAbility - Hilltop Developmental Preschool: 1915 E. 86th Street Indianapolis, IN 46240 (Ages 4-10)

☐ **Session 1:** June 12 – June 22 (Mondays – Thursday)

☐ **Session 2:** June 26 – July 7 ***PLEASE NOTE: THE 1st WEEK OF SESSION 2 WILL RUN M-F AND THE 2ND WEEK WILL RUN WEDNESDAY-FRIDAY DUE TO THE 4TH OF JULY**

☐ **Session 3:** July 10 – July 20 (Mondays – Thursday)

Payment Information (please check one):

☐ **CHECK** (*made payable to Easterseals Crossroads):*

I have enclosed a check in the amount of $ _____ to cover the $100 deposit that is due for **each session** that we have indicated we'd like to attend.

☐ **CREDIT/DEBIT:**

I authorize Easterseals Crossroads to charge my credit/debit card in the amount of $_____ to cover the $100 deposit that is due for **each session** that we have indicated the above listed participant will attend.

Credit Card: ☐ Master Card ☐ Visa ☐ Discover Card ☐ American Express

Credit Card Number: _____ Expiration Date: _____

_____ _____

Cardholder's Printed Name Cardholder's Signature

Once we receive the completed registration forms and payment, we will send you a confirmation letter letting you know that your spot for camp has been reserved.

Authorization to use Likeness/Information

Consumer Name _____ Date of Birth _____

I, or my legal representative, understand and agree that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of me made by Easterseals Crossroads or its respective employees and agents may be used by Easterseals Crossroads and those acting with its permission for the purpose of illustration, broadcast, or testimonial in connection with the work of Easterseals Crossroads and that these materials may be released to the general public. I assign to Easterseals Crossroads all of my rights to these materials.

I understand that these materials made by Easterseals Crossroads, its employees and agents are owned by Easterseals Crossroads and that they may copyright them. I further consent to allow Easterseals Crossroads, their respective employees and agents, and those acting with Easterseals Crossroads' permission to use my protected health information, as defined under 45 C.F.R. 164.501, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easterseals Crossroads and to release this information to the general public.

I understand that these materials may be published by Easterseals Crossroads on the Internet. This may disclose my image, name and diagnosis, which is considered personal and protected health information. Easterseals Crossroads does not need to submit these materials to me for further approval and I further understand that Easterseals Crossroads may decide not to use these materials.

I acknowledge that the rights described above are granted to Easterseals Crossroads on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easterseals Crossroads will not condition any treatment or funding to me on the completion of this authorization. I also understand that I may revoke my consent to allow Easterseals Crossroads to release my protected health information, including image, name and diagnosis if the information has not already been disclosed. To revoke my consent, I must notify Easterseals Crossroads in writing by sending my revocation to Easterseals Crossroads, Marketing Department, 4740 Kingsway Drive, Indianapolis, IN 46205.

I understand and agree that once Easterseals Crossroads, its respective employees and agents, and those acting with its permission disclose my protected health information, including image, name and diagnosis, as contemplated by this release, this information is subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. This release and authorization expires five years from the date of my signature below.
I have read this release and authorization before signing below, and I fully understand its contents.

_____ _____

Signature of Consumer or Legal Representative | Date

_____ _____

Printed Name of Consumer or Legal Representative | Relationship to Consumer

_____ _____

Witness | Date

MORNING DOVE THERAPEUTIC RIDING INC.
Mailing: PO Box 721, Zionsville, IN 46077
Location: 7444 W. 96th Street, Zionsville, IN 46077
Telephone (317) 733-9393; Fax (317)733-9353

PARTICIPANT RELEASE AGREEMENT

I, _____, [OR, if participant is under 18 or not legally competent, then, I, the undersigned parent / parents and / or guardian / guardians on behalf of _____ a minor] for and in consideration of the agreement with Morning Dove Therapeutic Riding Inc. to provide equine assisted activities to said participant, does / do hereby forever release, acquit, discharge and hold harmless Morning Dove Therapeutic Riding Inc., its officers, trustees, agents, employees, representatives, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned or said participant may now, or in the future, have against Morning Dove Therapeutic Riding Inc. its officers, trustees, agents, employees, representatives, successors and assigns, on account of any personal injuries, physical or mental condition, known or unknown, to the person of said participant and the treatment therefore as a result of, or in anyway growing out of, the acts or omissions of Morning Dove Therapeutic Riding Inc., its officers, trustees, agents, employees, representatives, successors and assigns, including their own negligent acts or omissions, in rendering the services above described or in anyway incidental thereto. The undersigned acknowledges that Morning Dove Therapeutic Riding, Inc. is an equestrian professional under Indiana Code 34-31-5 and is immune from liability for certain acts and omissions described in the statute. The following notice is provided according to the statute:

WARNING

UNDER INDIANA LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO, OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES.

In no way shall the immunity afforded in Indiana Code 34-31-5 limit the scope of this release.

I have read and understand this release.

DATE: _____ SIGNED: _____

Print Name: _____ (Participant or Parent/Guardian if under 18 or not legally competent)

WITNESSED:_____

PHOTO RELEASE FORM

For valuable consideration given and which is hereby acknowledged, the undersigned hereby grant _____ does not grant _____ to Morning Dove Therapeutic Riding Inc. (MDTRC) permission to take or have taken, still and moving photographs and films including television pictures of _____ and consents and authorizes MDTRC, its advertising agencies, news media, and any other persons interested in MDTRC, and its work, to the use and reproductions of the photographs, films, and pictures to circulate and publicize the same by all means including without limit, the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material. With regard to the foregoing material, no inducements or promises have been made to us / me to secure our / my signature(s) to this release other than the intention of MDTRC to use or be used such photographs, films and pictures for the primary purpose of promoting and aiding its program and its work.

I have read and understand this release.

DATE: _____ Signed _____

(Participant or Parent/Guardian if under 18 or not legally competent)

PROPERTY OWNER RELEASE AND WAIVER OF LIABILIITY AND HOLD HARMLESS AGREEMENT

IN CONSIDERATION of being permitted to enter into property owned by Fortune Development, LLC and operated by Morning Dove Therapeutic Riding, Inc (hereinafter the "Farm") for any purpose, including but not limited to, horseback riding, other equine activities, observation, use of facilities or equipment, or participation in any way, the undersigned, for himself or herself and any personal representative, administrator, executor, heir, family member, successor and assign, hereby acknowledges, agrees and represents that he or she has, or immediately upon entering will, inspect such premises and facilities. It is further warranted that such entry into the Farm for horseback riding, other equine activities, observation, participation or use of any facilities or equipment constitute an acknowledgement that such premises and all facilities and equipment thereon have been inspected and that the undersigned finds and accepts same as being safe and reasonably suited for the purposes of such observation or use.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER THE FARM FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO, HORSEBACK RIDING, OTHER EQUINE ACTIVITIES, OBSERVATION, USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY WAY, THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING.

1. THE UNDERSIGNED HEREBY ACKNOWLEDGES that horses may, without warning, kick, bite, balk, stomp, stumble, rear, bolt, fall down, and react to sudden movements, noise, light, vehicles, other animals or objects. Equestrian activities involve equipment that may break, fail or malfunction. Other riders may not control their animals, or ride within their ability, and cause a collision or other unpredictable consequences. Equestrian activities may be conducted in areas which are subject to constant change in condition according to weather, temperature, and natural and man-made changes in the landscape, including the riding ring, where objects are not marked and hazards may not be visible; where trails are not groomed, maintained or controlled; where weather is changeable, unpredictable and dangerous; and where lightning, thunder, beehives, streams, creeks, fallen timber, wild animals and other hazards and dangers exist.
2. THE UNDERSIGNED HEREBY RELEASES, WAIVES DISCHARGES AND COVENANTS NOT TO SUE EITHER FORTUNE DEVELOPMENT, LLC OR MORNING DOVE THERAPEUTIC RIDING, INC., its trustees, directors, officers, employees, and agents (hereinafter referred to as "releasees") from all liability to the undersigned, his or her personal representatives, administrators, executors, heirs, family members, successors and assigns for any loss or damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned, whether caused by the negligence of the releasees or otherwise while the undersigned is in, upon, or about the premises or any facilities or equipment therein. In the event that an attorney is engaged to enforce, construe, or defend any of the terms, conditions or claims or demands covered by this RELEASE AND WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT, either with or without suit, the UNDERSIGNED agrees to pay all attorneys' fees and costs incurred by the releasees.
3. THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND HOLD HARMLESS the releasees and each of them from any loss, liability, damage or cost they may incur due to the presence of the undersigned in, upon or about the Farm for any purpose, including, but not limited to, horseback riding, other equine activities, observation, use of facilities or equipment, or participation in any way, whether caused by the negligence of the releasees or otherwise.
4. THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE due to the negligence of releasee or otherwise while in, about or upon the premises of the Farm and/or while using the premises for any purpose, including, but not limited to, horseback riding, other equine activities, observation, use of facilities or equipment, or participation in any way.

THE UNDERSIGNED further expressly agrees that the foregoing RELEASE, WAIVER AND HOLD HARMLESS AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of Indiana and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THIS RELEASE AND WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT, and further agrees that no oral representations, statements or inducement apart from the foregoing written agreement have been made.

WARNING

Under Indiana Law, an equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

I HAVE READ THIS RELEASE (Rider/Guest 18 years of age or over):

Date _____ Signature of Rider/Guest: _____
Print Rider/Guest's Name: _____

Address: _____
Phone: _____ Email address: _____

I HAVE READ THIS RELEASE (Parent/Guardian if Rider/Guest is under 18 years of age or not legally competent)

Date _____ Signature of Parent/Guardian: _____
Print Parent/Guardian Name: _____
Print Name of Rider/Guest: _____
Address: _____
Phone: _____ Email address: _____

MORNING DOVE THERAPEUTIC RIDING INC.

EMERGENCY RELEASE

Participant Name_____**Parent/Guardian**_____

Physician's Name_____ **Physician's Phone** _____

Person who is authorized to give temporary assistance or care in absence of parent or guardian:

Name_____ Phone _____ Relationship _____

Name_____ Phone _____ Relationship _____

Preferred Medical Facility:_____

Does this rider have a medical condition requiring special precautions or treatment including any medications and dosage: Yes/No _____ If yes, please describe _____

_____

In case of medical emergency, the undersigned authorizes Morning Dove Therapeutic Riding Inc. to provide such medical assistance as they determine to be necessary.

The undersigned authorizes any licensed physician and / or medical facility to provide any medical / surgical care and / or hospitalization for the rider, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent form from the undersigned.

No person can be accepted for program participation until this form has been completed by the parent / parents or guardian. If the person is of legal age (18), he or she may complete the form, if he or she is legally competent to do so. Riding instruction will be under strict supervision, and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations concerned, including Morning Dove Therapeutic Riding Inc..

_____ **Date:** _____

SIGNATURE OF PARENT / PARENTS OR GUARDIAN

_____ **Date:** _____

SIGNATURE OF PARTICIPANT IF OVER AGE 18

MORNING DOVE THERAPEUTIC RIDING INC.

PO Box 721, Zionsville, IN 46077
Telephone: (317) 733-9393 Fax: (317) 733-9353

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant:_____DOB:_____Height:_____Weight: _____
Address:_____
Diagnosis:_____
_____ Date of Onset:_____ Past / Prospective
Surgeries: _____
Medications:_____
Seizure Type: _____ Controlled: Y N
Date of Last Seizure: _____
Shunt Present: Y N Date of last revision: _____
Special Precautions/Needs: _____
_____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Spinal injury: Y N Point of injury: _____ Braces/Assistive Devices: _____

Down Syndrome: Atlanto Dens Interval X-rays, date:_____ Results: + -
Neurological Symptoms of Atlanto Axial Instability:_____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Incontinence (Other)			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Which, if any of the following conditions are present?

_____ Prior surgeries – physician release required post surgery
_____ Planned surgeries – physician release required post surgery
_____ Equipment/Medical Devices – participant cannot go without use of the equipment/medical device for 60 minutes OR the participant has indwelling urethral catheter
_____ Condition which may require immediate medication
_____ Condition which may be exacerbated by environmental factors (e.g., weather, presence of certain allergens)
_____ Recent seizure activity
_____ Active substance abuse

Explanation of any checked items above:

_____
_____
_____
_____
_____
_____

General Observations or comments about this patient:_____
_____
_____
_____
_____

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

Name/Title:_____ MD DO NP PA Other_____
Signature:_____Date_____
Address:_____
Phone:_____ License/UPIN Number_____

Physician's Medication Administration Form

Participant's Name _____

Date of Birth _____ Child's Weight _____

PRESCRIPTION MEDICATIONS (MUST BE PROVIDED IN THE ORIGINAL CONTAINER)

Camp staff have permission to give the above listed participant, _____,
the following medication(s) _____

Day(s)/Time(s) to be given _____

Dosage/Route _____

Reason for medication _____

Should the medicine be taken with food or milk? _____Yes _____ No

Any other special instructions? _____

_____

OVER-THE-COUNTER MEDICATIONS (MUST BE PROVIDED IN THE ORIGINAL CONTAINER)

Do you want camp and enrichment staff to administer over-the-counter medications when necessary and then according to recommended dosage for the child's weight/age? _____ Yes _____ No

If yes, what medications will you provide for your child to take and for what purpose?

_____

_____

_____ _____

Printed Name of Physician **Physician's Signature**

_____ _____

Physician's Phone Number **Physician's Address**

_____ _____

Parent/Legal Guardian Signature **Date**

Scholarship Application Form

A limited number of scholarships are available for the camp and enrichment programs at Easterseals Crossroads. Please complete this form to apply for a scholarship, and return it with your registration form. Please note that we can only scholarship one session of camp or enrichment programs and that the family is still responsible for the $100 deposit even if awarded the scholarship.

It is necessary to include a copy of your most recent tax return and the following if applicable:

- A copy of your last two month's pay stubs
- If unemployed, a copy of your last two month's unemployment check stubs
- Copy of paperwork documenting retirement, disability or social security benefits
- Copy of document citing child support or alimony awarded by a judge

This information will only be used to determine scholarship eligibility.

CONSUMER INFORMATION	
Child's name:	Parent's Name:

HOUSEHOLD INFORMATION

Number of family members in household:

____ Mother ____ Father

____ Children ____ Other Adults

Gross Annual Income (including parent's earned income, child support, disability income, and worker's compensation):

$ _____

SIGNATURE

Signature of individual providing information:

Patient/Guardian signature *Date*

For Office Use Only:

____ Scholarship approved and family notified

____ Scholarship denied and family notified

Before and After Care

Participant Name: _____ Date: _____

Easterseals Crossroads is pleased to offer before and after care to children who participate in CampAbility. Families interested in receiving care, must complete the form below and attach the appropriate payment. The cost for before and after care is in addition to the regular camp fee. Please note the fee structure below. We encourage families to pre-arrange before and after care, as we cannot guarentee the availability of staff for care on an as-needed basis.

Pre-arranged (on or before June 5, 2017): $7 per hour, per child
As-needed basis (after June 5, 2017): $10 per hour, per child

Directions: Please check (x) the boxes that express the dates/times you are interested in receiving before and after care for the above listed participant.

Session 1: June 12 - June 22				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, June 12				
Tuesday, June 13				
Wednesday, June 14				
Thursday, June 15				
Monday, June 19				
Tuesday, June 20				
Wednesday, June 21				
Thursday, June 22				
			TOTAL DUE:	$
Session 2: June 26 – July 7				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, June 26				
Tuesday, June 27				
Wednesday, June 28				
Thursday, June 29				
Friday, June 30				
Wednesday, July 5				
Thursday, July 6				
Friday, July 7				
			TOTAL DUE:	$
Session 3: July 10 – July 20				
Date	**8a – 9a @ $7**	**3p-4p @ $7**	**4p-5p @ $7**	**Payment Total/Day**
Monday, July 10				
Tuesday, July 11				
Wednesday, July 12				
Thursday, July 13				
Monday, July 17				
Tuesday, July 18				
Wednesday, July 19				
Thursday, July 20				
			TOTAL DUE:	$
			GRAND TOTAL DUE: *(add totals from session 1, 2 and 3)*	$

I agree to pay the fees listed above. I understand that if plans change and I no longer need before or after care for my child on a date that I have indicated, I will be reimbursed those fees at the conclusion of camp.

Parent/Caregiver Signature: _____ Date: _____

Frequently Asked Questions

What should the participant bring to camp?

- Extra change of clothes (or two!)
- A pair of long pants
- Diapers, pull-ups, or extra underwear; wipes
- Sunscreen, swim diaper, swimsuit, towel, sandals (for water play)
- A sack lunch – we do have access to a refrigerator
- A cup – if a special one is needed for drinking
- A snack (if your child has specific dietary restrictions)
- Medication - be sure to notify staff if medications are needed
- Sensory toys/chewable toys (if needed)
- Communication device (if appicable)

What should the participant wear to camp?

- Comfy clothes – shorts, light t-shirts, etc.
- Camp shirt – on field trip days only
- Gym shoes / closed toed shoes
- It gets chilly at times in our classrooms! An extra sweater or sweatshirt is also recommended!

Will there be an open-house where my child can meet the staff and see their classroom?
Yes! We have scheduled an open house on Thursday, June 8, from 5-6 at the camp site where you have registered. Bring your child and show them their classroom, introduce them to staff and get the camp calendar so you will know what fun-filled activities we have scheduled! ☺

'Typical' camp schedule

9:00-9:30: welcome / circle time
9:30-10:30: exercise time / gross motor activities
10:30-11:30: water play
- we have small swimming pools (less than 2 ft deep), water slides, sprinklers and water toys

11:30-1:00: lunch and recess
1:00-2:30: stations
- arts and crafts
- snack time
- circle time

2:30-3:00: home rooms for play / prepare to go home

Sick policy
We want to ensure that all children that come to camp are healthy and free of illness so that others do not get sick. Children attneding camp must be free from fever, vomiting, and/or diarrhea for 24 hours. In addition, children must be not present with a contagious illness. Should your child be ill, please contact Angie Hilligoss at 317-662.4398. Additionally, if your child becomes ill while with us at camp, we will contact you to arrange pick-up.