

**OHIO STATE SCHOOL FOR THE BLIND  
5220 NORTH HIGH STREET  
COLUMBUS, OHIO 43214  
(614) 752-1152 or (800) 310-3317**

**SUMMER 2010 CAMP APPLICATION FORM**

Please select the camp that you are interested in attending, and check the row(s) accordingly. Students will be selected for camps according to availability.

<b>Camp</b>	<b>Enrichment Camp</b>	<b>Dates</b>	<b>Student's Grade &amp; Ages</b>
	Braille Immersion	June 14-18, 2010	Grades 3-7; Ages 8-13
	Technology	June 14-18, 2010	Grades 9-12 in fall of 2010

**General Information:**

PARTICIPANT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_

PARENT(S) NAME(S) \_\_\_\_\_

PARENT'S TELEPHONE: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

EMERGENCY TELEPHONE\* \_\_\_\_\_

\*Complete Consent for Emergency Treatment/OSSB Medical Form A-1 (Will be sent with registration packet from OSSB)

CURRENT GRADE LEVEL OF STUDENT \_\_\_\_\_

CURRENT SCHOOL INSTRUCTOR OR CONTACT \_\_\_\_\_

CURRENT DISTRICT AND SCHOOL ATTENDING \_\_\_\_\_

CURRENT SCHOOL PHONE NUMBER \_\_\_\_\_

**Health Information:**

Cause of Visual Impairment or Blindness\_\_\_\_\_

Amount of Remaining Vision: Left Eye\_\_\_\_\_Right Eye\_\_\_\_\_

Additional Disabilities: (Please explain)\_\_\_\_\_

\_\_\_\_\_

Allergies (include reactions to specific foods): \_\_\_\_\_

Medications: \_\_\_\_\_

\*Complete Medication Authorization A-2 (Will be sent with registration packet from OSSB)

Behavioral Concerns: (Please explain)\_\_\_\_\_

\_\_\_\_\_

**School Information:**

1. What type of technology or adaptive equipment does your child presently use?

\_\_\_\_\_

2. What level of Braille skills does your child presently have?\_\_\_\_\_

\_\_\_\_\_

3. How long has he or she been a Braille reader? \_\_\_\_\_

4. What is your child's present reading level?\_\_\_\_\_

5. What is your child's present math level?\_\_\_\_\_

6. What are your child's favorite subjects?\_\_\_\_\_

\_\_\_\_\_

7. What subject(s) does your child perform best academically?\_\_\_\_\_

\_\_\_\_\_

**Mobility Information:**

1. Please check one, which most closely describes your community:  
 Rural                       Urban                       Suburban
  
2. Can your child travel independently in your neighborhood?  Yes     No
  
3. Can your child cross streets or roads independently near your home?  
 Yes     No
  
4. Please check all types of streets, roads and intersections you know your child can cross safely:  
 A quiet residential street                       A busy residential street  
 Two-way stop sign intersection                       Traffic light with two busy main streets  
 Other: \_\_\_\_\_  
\_\_\_\_\_
  
5. Can your child travel at night?  Yes     No
  
6. In addition to the visual impairment, are there any special problem(s) or circumstances that prevent your child from traveling outside alone in your neighborhood?  
\_\_\_\_\_  
\_\_\_\_\_
  
7. Please check services that student has received:  
 Vision Stimulation and/or Training                       Concept Development  
 Sensory Training                       O&M Training  
 Low Vision Evaluation                       Other \_\_\_\_\_
  
8. Are you aware of any orientation or mobility needs that the student has which are presently not being met or planned for?  
\_\_\_\_\_
  
9. Please list any mobility or low vision aids that your child uses. (If equipment is owned or on loan, please bring with you to summer program).  
\_\_\_\_\_

**Please send application to: Ohio State School for the Blind  
Attention: Summer Camp Registration  
5220 N. High Street  
Columbus, OH 43214**

**If your child is selected to participate, notification will be provided through the U.S. mail along with registration forms which must be completed and returned to OSSB no later than May 14, 2010, for your child to attend camp.**

**If you have questions, please contact OSSB at (800) 310-3317 or (614) 752-1152.**