

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

SUMMER 2012 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.

Camp	Enrichment Camp	Dates	Student's Grade & Ages
	Braille Immersion	June 11-15, 2012	Entering Grades 3-7, Ages 8-12 in Fall 2011
	Science, Technology, Engineering & Math (STEM)	June 11-15, 2012	Entering Grades 8-12, Ages 13-18 in Fall 2011

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 25, 2012, for your child to attend camp.

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

**OHIO STATE SCHOOL FOR THE BLIND
EMERGENCY TREATMENT/ MEDICAL FORM A-1**

Name:	
DOB:	
SS#:	
Parent/Guardian:	
Home Address:	
Cell Phone:	
Work Phone:	
Emergency Phone Contact:	
Last Tetanus:	
Allergies:	
Family Doctor:	
Eye Doctor:	
Eye Condition:	
Medicaid # (Send Copy):	
Insurance # (Send Copy):	

Part I—Please check one box for each item

1. **Medical Treatment**

I authorize the provision of medical treatment for my child by a **school nurse and/or school physician** when my child becomes ill or injured while under school authority.

I **do not give consent** and I wish the school authorities to take the following action: _____

Signature: _____

2. **Medication**

I hereby request and give my permission to the school nurse or his/her designee to administer medication to my child.

I **do not request and do not give permission** to the school nurse or his/her designee to administer medication to my child and I wish the school authorities to take the following action: _____

Signature: _____

Part II

Consent for Emergency Treatment:

In the event of an emergency and reasonable attempts to contact me have been unsuccessful, I hereby give my consent for 1) the administration of any treatment deemed necessary by the school physician; and 2) the transfer of my child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date: _____

Signature: _____

(Parent or Guardian)

Refusal to Consent:

I **do not give consent** for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

Date: _____

Signature: _____

(Parent or Guardian)

Updates since last school year concerning the child's medical history including **allergies** any physical impairments the school nurse should be aware of:

**OHIO STATE SCHOOL FOR THE BLIND
MEDIA RELEASE FORM
2012 SUMMER CAMP**

The Ohio State School for the Blind would like your permission to use pictures or images of your child:

1. In the promotion of the school and its programs.
2. In the development of staff or parent training materials.
3. In the publication and advertising of Special Education materials.
4. In the communication of personal accomplishments of interest to the general public through the news media (i.e., scholarship award received, or athletic achievements).

No mention of your child's name will be made in items 1-3 above. Your child's name will be mentioned when an appropriate news item is specific to him/her as described in item 4 above.

I hereby give the staff at the Ohio State School for the Blind, permission to take, to show, or to publish, photographic portraits and video images of my son/daughter _____ . This permission is effective during and beyond the course of the 2012 Summer Camps at the Ohio State School for the Blind.

Signature Parent/Legal Guardian

Date

**OHIO STATE SCHOOL FOR THE BLIND
MEDICATION AUTHORIZATION
2012 SUMMER CAMPS/PROGRAMS**

Name of Student: _____

Allergies: _____

MEDICATION	DOSAGE	TIME

ALL MEDICATIONS MUST BE IN THE ORIGINAL PHARMACY LABELED CONTAINER

I/we understand the parental responsibility to be 1) to deliver the medication to school in the original prescription bottle and give medication to school nurse; 2) have the MEDICATION AUTHORIZATION completed and signed by prescribing physician for all medication that is to be administered at school; and, 3) to recover any medication not administered at school.

Date

Signature of Parent/Legal Guardian

PHYSICIAN'S AUTHORIZATION FOR THE DISPENSING OF MEDICATION BY OSSB PERSONNEL

The above-mentioned student is under my care and should receive the medications as listed.

Date

Physician's Signature