

Oklahoma School for the Blind  
**Outreach Services Application**  
 SY 2022-2023

STUDENT'S INFORMATION		
Name of Child:		
(Last)	(First)	(M.I.)
Date of Birth:	Age:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
City of Birth:		State of Birth:
Current Mailing Address:		
City:	State:	Zip:
Race/Ethnicity:	Current Grade Level:	
Are you requesting placement for the student at the Oklahoma School for the Blind? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Where will the assessment be completed at: OSB <input type="checkbox"/> Student's Home <input type="checkbox"/> Student's Primary School <input type="checkbox"/>		
Reason for Referral:		
Guardian Information		
Name of Parent/Guardian:		
(Last)	(First)	
Mailing Address: ( <input type="checkbox"/> Same as Child)		
City:	State:	Zip:
Phone:	2 <sup>nd</sup> Phone:	Email:

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School Information		
Name of School Student Attends:		
School <b>Physical</b> Address:		
City:	State:	Zip:
School <b>Mailing</b> Address:		
City:	State:	Zip:
Phone:	Fax:	Website:
School <b>Contact Person</b> for Services:		
Phone:	Fax:	
Cell phone:		
Mailing Address:		
City:	State:	Zip:
Email:		
Special Education Director/Sooner Start Contact:		
Mailing Address:		
City:	State:	Zip:
Phone:	Fax:	Email:
Vision Teacher Contact:		
Mailing Address:		
City:	State:	Zip:
Phone:	Fax:	Email:

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Special Education Information
Primary Disability Relating to Visual Impairment (Include Physician Diagnosis):
Additional Medical Diagnosis:
Does the Student Walk Independently? Yes <input type="checkbox"/> No <input type="checkbox"/>
If Not, How Does the Student travel? (Walk, Wheelchair, Walker, etc)
Does the Student Use A White Cane? Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the Student Use Verbal Communication? Yes <input type="checkbox"/> No <input type="checkbox"/>
Please List Student's Mode of Communication:

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Health & Medical History		
Are There Medical/Health Concerns? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Please List:		
Toilet Trained Yes <input type="checkbox"/> No <input type="checkbox"/>	GI Tube Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizure Disorder Yes <input type="checkbox"/> No <input type="checkbox"/>
Hearing Impairment Yes <input type="checkbox"/> No <input type="checkbox"/>		Allergies Yes <input type="checkbox"/> No <input type="checkbox"/>
Please List All Allergies:		
Current Medications & Time Given:		
Does the Student Have Any Behavioral Concerns? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If so, please list:		
Any Additional Medical Information:		

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Services Available		
Please Choose the Services that are Being Requested for the Student		
<i>Available at the Student's Primary School or Home</i>		
Functional Environment Assessment Yes <input type="checkbox"/> No <input type="checkbox"/>	Functional Vision Assessment Yes <input type="checkbox"/> No <input type="checkbox"/>	
Orientation & Mobility Yes <input type="checkbox"/> No <input type="checkbox"/>	Visual Consultation for IEP Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>Available at the Oklahoma School for the Blind</i>		
Academic Evaluation Yes <input type="checkbox"/> No <input type="checkbox"/>	Assistive Technology Yes <input type="checkbox"/> No <input type="checkbox"/>	Developmental Evaluation Yes <input type="checkbox"/> No <input type="checkbox"/>
Independent Living Skills (ILS) Yes <input type="checkbox"/> No <input type="checkbox"/>	Intellectual Evaluation Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Vision Screening Yes <input type="checkbox"/> No <input type="checkbox"/>
Occupational Therapy Yes <input type="checkbox"/> No <input type="checkbox"/>	Physical Therapy Yes <input type="checkbox"/> No <input type="checkbox"/>	Speech-Language Pathology Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>To Be Completed By Person Completing Application</b>		
Name of Person Completing Application:		
Email:		
Phone:		
Relation to Student: Parent <input type="checkbox"/> Teacher <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/> (Please Specify) _____		