Oklahoma School for the Blind

Outreach Services Application

SY 2019-2020

STUDENT'S INFORMATION		
Name of Child:		
(Last) (First) (M.I.)		
Date of Birth:		Gender: M ☐ F ☐
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 ☐ No ☐		
Where will the assessment be completed at: OSB ☐ Student's Home ☐ Student's Primary School ☐		
Reason for Referral:		
Guardian Information		
Name of Parent/Guardian:		
(Last)	(First)	
Mailing Address: (☐ Same as Child)		
City:	State:	Zip:
Phone:	2nd Phone:	Email:

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School Information		
Name of School Student Attends:		
School **Physical** Address:		
City:	State:	Zip:
School **Mailing** Address:		
City:	State:	Zip:
Phone:	Fax:	Website:
School **Contact Person** 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:

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

Health & Medical History		
Are There Medical/Health Concerns? Yes ☐ No ☐		
Please List:		
Toilet Trained Yes ☐ No ☐	GI Tube Yes ☐ No ☐	Seizure Disorder Yes ☐ No ☐
Hearing Impairment Yes ☐ No ☐		Allergies Yes ☐ No ☐
Please List All Allergies:		
Current Medications & Time Given:		
Does the Student Have Any Behavioral Concerns? Yes ☐ No ☐ 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		
Available at the Student's Primary School or Home		
Functional Environment Assessment Yes ☐ No ☐		Functional Vision Assessment Yes ☐ No ☐
Orientation & Mobility Yes ☐ No ☐		Visual Consultation for IEP Yes ☐ No ☐
Available at the Oklahoma School for the Blind		
Academic Evaluation Yes ☐ No ☐	Assistive Technology Yes ☐ No ☐	Developmental Evaluation Yes ☐ No ☐
Independent Living Skills (ILS) Yes ☐ No ☐	Intellectual Evaluation Yes ☐ No ☐	Low Vision Screening Yes ☐ No ☐
Occupational Therapy Yes ☐ No ☐	Physical Therapy Yes ☐ No ☐	Speech-Language Pathology Yes ☐ No ☐
To Be Completed By Person Completing Application		
Name of Person Completing Application:		
Email:		
Phone:		
Relation to Student: Parent ☐ Teacher ☐ Guardian ☐ Other ☐ (Please Specify)_____		