Oklahoma Department of Rehabilitation Services

Oklahoma School for the Blind www.okdrs.gov

OKLAHOMA SCHOOL FOR THE BLIND (OSB)

To: Interested Instructors, Parents, Guardians, and Students
Re: Summer Camp Application form
Date(s): June 1, 2020 – June 11, 2020

Thank you for your interest in OSB's Summer Camp Program. Please complete the application and **return the application forms as soon as possible to OSB**:

Mail to: Oklahoma School for the Blind
Attn: Summer Camp Director
3300 Gibson St.
Muskogee, OK 74403
Or Email to: scoplen@osb.k12.ok.us

The deadline for submission is April 24, 2020.

The camp is 2 weeks long and will run from June 1 through June 11. Students will go home on the weekend of June 5-7. Summer camp will be dismissed at 3:00p.m. on Thursday, June 4 and students will return on Sunday, June 7. Camp will end at 3:00p.m. on Thursday, June 11.

Check In: Sunday, May 31, 2020.

8th – 11th grade	**1:00 - 2:00**
4th – 7th grade	**2:00 – 3:00**
K – 3rd grade	**3:00 – 4:00**

Unless otherwise indicated, all forms are to be completed by parent / legal guardian. Please feel free to attach a letter to this application describing concerns you may have regarding your child or anything that would help us know your child better.

Students must submit the following information with the application forms:

- ☐ Current eye report
- ☐ Current immunization (shot) records
- ☐ Copies of health insurance cards
- ☐ Medical information, including any physician's orders with physical restrictions, allergies, and list of current medications
- ☐ Indian Tribal Card, if applicable

School Child Currently Attends (LEA): ______________________________

VI Teacher Name: ______________________________

VI Teacher Contact Phone: (________) ____________________

Appendix A

STUDENT INFORMATION / SCHOOL RELATED
(this page to be completed by teacher / LEA)

This form should <u>be completed by the teacher</u> most knowledgeable about the student's program and returned to Oklahoma School for the Bind.

Name of Student: ______________________________

Relationship to student: ☐ Teacher ☐ Para ☐ Other: ____________________

Phone #: (_______) ______________________________

Current Grade Placement: _______

Strengths:

____

____

Weaknesses:

____

____

Type of Program the student is currently enrolled:

_____ Inclusion in regular classroom _____ Special Ed. Full or Part-Time

_____ Behavior Program _____ VI Consultation Basis

Check any of the following which apply to the student:

_____ Glasses _____ Contact Lens _____ Magnifier _____ CCTV

_____ Telescope _____ Other Adaptations _____ Cane

Does your student use:

_____ Print _____ Braille _____ Both _____ N/A

EMERGENCY CONTACT INFORMATION

In the event of an emergency it is essential that we have accurate **contact information for you**.

Student Name: ______________________________ ☐ Male ☐ Female

DOB: ______________ Age: ________ Grade level ______

Parent or Legal Guardian: ____

Address: ____

City: ______________________________ Zip Code: ______________

Home Phone: (_______) ___________________

Work Phone: (_______) ___________________

Cell Phone: (_______) ___________________

E-mail Address: ____

Emergency Contact/s: Please list, in preferred order, two other people we should contact in the event we are unable to reach you in an emergency.

Name (please print): ____

Relationship to Student: ____

Emergency Telephone: (______) _______________________

Name (please print): ____

Relationship to Student: ____

Emergency Telephone: (______) _______________________

MEDICAL INFORMATION / PERMISSIONS

☐ Yes ☐ No — I give **permission to administer over the counter (OTC) medication** (i.e. Tylenol, cough syrup). – If NO, please list any restriction/s regarding OTC medications (use additional paper as needed):

- ______________________________
- ______________________________

☐ Yes ☐ No — **Any history of seizures?** - If yes, please list symptoms and date of last seizure:

- ______________________________
- ______________________________

☐ Yes ☐ No — **Does your child have a shunt?** - If yes, please describe.

- ______________________________
- ______________________________

☐ Yes ☐ No — **Should your child be restricted from any type of recreation or physical activity?** - If yes, please explain:

- ______________________________
- ______________________________

☐ Yes ☐ No — **Does your child have any diet restrictions / food allergies?** - If yes, please list:

- ______________________________
- ______________________________

NOTE: MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER WITH YOUR CHILD'S NAME ON THE LABEL AND BE PRESCRIBED BY A DOCTOR.

IF YOUR CHILD HAS ADRENAL INSUFFICIENCY, ASTHMA, DIABETES, OR SEIZURES - PLEASE REMEMBER TO BRING ALL EMERGENCY MEDICATIONS AS WELL AS AN ACTION PLAN FOR THE FIRST THREE CONDITIONS LISTED.

Please list all medications your child currently takes (use additional paper as needed):

- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________

Please list below **any special health problems** including allergies and any other health information that may be useful in the event of an injury or illness (use additional paper as needed):

- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________

AUTHORIZATION FOR MEDICAL CARE OF A MINOR - OSB

I the undersigned parent or person having legal custody or the legal guardianship of ______________________________ DO HEREBY AUTHORIZE a representative of Oklahoma School for the Blind to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a physician, surgeon or dentist licensed under the laws of the State of Oklahoma.

IN GIVING THIS CONSENT I RECOGNIZE AND UNDERSTAND that in situations where the above named minor requires immediate medical or hospital care it may not be possible to contact me, and that in such situations I will not be able to knowledgeably evaluate and choose among the available alternative treatments or procedures, if any, or to evaluate the risk attendant upon each, and the risks attendant to forgoing all treatment; in such situations, I authorize a physician, surgeon or dentist to exercise his professional judgment and assess the risks incident to and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he in his professional judgment determines to be necessary for the health or safety of the above named minor.

_________________ ____

Date (Signature of parent or person having legal custody/guardian.)

Print name:____

____

(Street Address)

____ ____________________

(Mailing Address) Phone

(List who to contact in an emergency if unable to reach you.)

Name	Relationship	Phone number
______________________________	________________	_________________
______________________________	________________	_________________
______________________________	________________	_________________

TREATMENT INFORMATION: (**Please complete ALL information**.)

Minor's Birth Date: __________________ SSN: ________________________________

Insurance/Sooner care: ____

Allergies: (food or medications) ____

Date of last tetanus shot: _________________

Routine Medication being taking: ____

____

____

Medical History/Diagnosis: ____

____

____

Visual Diagnosis: ____

Visual Acuity: ____

Doctor (Name/Telephone No.): ____

PERMISSIONS AND RELEASES

☐ **Yes, I do** / ☐ **No, I do <u>not</u>** authorize Oklahoma School for the Blind Superintendent or designated employee/s to act on my behalf in case of needed emergency medical care for my child in the event I am unable to be contacted. I will be notified immediately of my child's condition and treatment.

☐ **Yes, I do** / ☐ **No, I do <u>not</u>** give OSB authorization to take my child to the nearest hospital if emergency services become necessary.
If Yes: If my child is taken to a hospital for emergency services and I cannot be reached, I will take full responsibility for the medical cost.

☐ **Yes, I do** / ☐ **No, I do <u>not</u>** confirm that my child has permission to attend school-sanctioned activities. Students are accompanied by school employees and transported in school vehicles for various activities.

☐ **Yes, I do** / ☐ **No, I do <u>not</u>** give consent for my child to learn about his/her eye condition and appropriate modifications and adaptations.

☐ **Yes, I do** understand that if my child is found in possession of drugs, alcohol, weapons, or any other contraband, he/she will be expelled from OSB Summer Camp and I will be called to immediately come to the school and pick up my child.

☐ **Yes, I do** understand that OSB's Summer Camp cannot accept participants who might endanger themselves or other people. By checking yes, I am stating that my child does not have any violent tendencies and has never injured anyone, including himself/herself.

☐ **Yes, I do** understand that OSB's Summer Camp cannot accept participants who are not independent in their living skills (showering, dressing, toileting, eating).

☐ **Yes, I do** / ☐ **No, I do <u>not</u>** give consent that photographs, and/or electronic images of my child be released in newspapers, magazines, brochures, school films, website or other types of media regarding Short Term Programs.

☐ **Yes, I do** / ☐ **No, I do <u>not</u>** give consent for information about my child and his/her progress in OSB Summer Camp to be released to his/her local school.

PERMISSIONS AND RELEASES (continued)

The following people have permission to visit or call my child at school, take my child off campus, pick up and/or transport my child to/from school and/or from the bus stop:

Name (please print): ______________________________

Relationship to Student: ______________________________

Telephone: (________) ______________________

Name (please print): ______________________________

Relationship to Student: ______________________________

Telephone: (________) ______________________

Parent/Guardian Signature: ______________________________

Date: ______________

LEARNING OBJECTIVES

The OSB Summer Program is designed to provide students who attend with unique educational opportunities, specific skill training, and access to specialized equipment and leisure activities.

During summer camp we work on all areas of the Expanded Core Curriculum. These skills include Braille, Independent Living Skills, Assistive Technology, Orientation & Mobility, and Recreation and Leisure. We also work on Compensatory skills to accommodate for their visual impairment.

PLEASE RETURN APPLICATION/S TO:

Oklahoma School for the Blind - Attn: Summer Camp Director
3300 Gibson Street, Muskogee, OK 74403
or Email: scoplen@osb.k12.ok.us

For Questions, please call: (918) 781-8200,
Toll Free in OK 1-877-229-7136 or send an email to above listed email address.