

Student Name: _____

IT'S THAT TIME!!!



**The Arkansas School for the Blind
Proudly announces the 2008 Summer Enrichment Program!**

Do you want your child to have a SUPER summer?

**This year's 3 week camp will focus on literacy,
Technology, social and motor skills, and Orientation and
Mobility!**

For visually impaired students ages 5-15.

Please Note: ASB summer programs are enrichment programs and, while offer some tutoring services, cannot meet the needs of Individualized Educational Program (IEP) need for extended school year services.

June 8 - 27th, 2008

Student Name: _____

Social Security Number: _____ Date of Birth: _____

Grade Completed as of June 2008: _____ Age: _____

Parent/Guardian Name: _____

Home Address:

Home Telephone Number:

Work or Second Telephone Number:

Name and phone number of the person to contact in case of an emergency or if parent/legal guardian cannot be reached:

Name and relationship of Individual(s) with whom the student is allowed to leave the ASB Summer Camp Site:

Name and telephone number of Individual(s) who will be responsible for the student's Summer Camp Transportation Needs:

1 _____

2 _____

3 _____

My child will be a residential camper at ASB _____.

My child will be a day camper at ASB _____ and does not need a dorm room.

Student Name: _____

Type and onset of Visual Impairment:

Visual Acuity level: (describe how well your child sees)

Current Vision Specialists working your child:

Medical: _____

Educational: _____

What adaptations are required for your child to be successful within a classroom setting? Please attach a copy of your's child's most recent annual review/IEP in order for our educational staff to meet the individual needs of your child. And what writing medium do they use? Large print, Braille, CCTV, etc.

What adaptations are required for your child to be successful within a recreational/outdoor setting.

Any other important information about your child that you would like to share:

**Is your child on his/her grade level for all core subjects? Yes__
No__**

If no, please list the areas in which your child struggles and the grade level on which he/she functions best.

Does your child take the ACTAAP benchmark tests or are they assessed through the portfolio? _____

Student Name: _____

MEDICAL INFORMATION:

Are shots current to date?

Height: _____ **Weight:** _____

Diagnosis/cause of vision loss:

Chickenpox/measles or other childhood diseases? Please list:

Are there precautions or limitations in regard to physical activities? Please list:

Known allergies to food, medications or insects? Please list:

Diet restrictions. Please list:

Specific Medical information/needs :

NOTE: MEDICATIONS CANNOT BE GIVEN TO STUDENTS WITHOUT AN ORDER FROM THE DOCTOR. THE MEDICINE BOTTLE IS NOT A PRESCRIPTION OR AN ORDER FROM THE DOCTOR. YOU MUST HAVE EITHER A PRESCRIPTION NOTE OR ORDER FROM THE DOCTOR.

Prescriptions your child is currently taking:

Your child's insurance company name and policy number:

Student Name: _____

APPLICATIONS WILL NOT BE CONSIDERED AFTER May 11, 2008. Please complete and return the application as soon as possible; a limited number of students will be accepted on a “first come, first serve basis”.