COLORADO CENTER for the BLIND

2233 West Shepperd Avenue, Littleton, Colorado 80120
Phone (303) 778-1130 (800) 401-4632 Fax (303) 778-1598
Email: ccb@cocenter.org Website: www.cocenter.org

APPLICATION

2017 Confidence Camp for Kids Elementary Program

For ages 5-11

Note: Applications will be reviewed based on the order received.

Date: _____

Child's Name_____

Date of Birth _____

Male_____ Female_____

Home Address_____

City _____ State _____ Zip Code _____

Father's or Guardian's Name _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email _____

Is this person approved to pick up student from the program? _____

Mother's or Guardian's Name _____

Home Address _____

City_____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email _____

Is this person approved to pick up student from the program? _____

Other persons approved to pick up student from the program: _____

_____

Who can we contact if we can't reach you in an emergency?

Name _____

Home Phone _____ Cell Phone_____

Email _____

Relation _____

Name of TVI_____

Phone_____

Email_____

Method used to study and take notes in school:

Braille _____ Large Print _____ Standard Print _____ Note taker_____

Other (please explain) _____

Method used to travel in school and in public:

Long White Cane _____ Sighted guide_____ None _____

Other (please indicate) _____

Health Statement

Please attach a copy of child's immunization record and medical insurance card.
In order for our staff to better understand your child, please complete the following medical information. Note there are no medical professionals on site at the Colorado Center for the Blind.

Child's name: _____

Date of last visit to physician or health exam: _____

Past history of serious injuries or illnesses: _____

_____

Cause of blindness: _____

Secondary disabilities: _____

Allergies: _____

Allergic reactions: _____

_____

Special dietary requirements: _____

_____

Any information that will help us in working with your child: _____

_____

_____

_____

Doctor's Name _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Medications currently being used:

1) Name of medication: _____

Medication is used for: _____

Date prescribed: _____

Directions for usage: _____

2) Name of medication: _____

Medication is used for: _____

Date prescribed: _____

Directions for usage: _____

Colorado Center for the Blind

Authorization for Emergency Medical Care

I hereby give my permission to the Colorado Center for the Blind officials to call a doctor or emergency medical service and for the doctor, hospital, or medical service to provide emergency medical or surgical care for (child's name) _____
should an emergency arise. It is understood that the Center officials will make a conscientious effort to locate the emergency contacts listed on the document before any action will be taken. If it is not possible to locate emergency contacts listed, I accept the expense of emergency medical or surgical treatment.

_____

Parent Name

_____

Parent Signature

_____

Date

Colorado Center for the Blind

Authorization to participate in the Colorado Center for the Blind Program Activities:

I hereby give permission for (child's name) _____ to go on trips away from the Center's premises, whether on foot or by vehicle, and to participate in all Center activities.

_____

Parent Name

_____

Parent Signature

_____

Date

Colorado Center for the Blind/National Federation of the Blind

Release for filming/interviewing

For children under 18 years of age and parent

I allow (child's name) _____ and/or myself to be videotaped, photographed and/or interviewed and I agree to allow said video, photo, film likeness or interview to be used or released to others for any legitimate purpose by the Colorado Center for the Blind or National Federation of the Blind.

_____

Parent Name

Parent Signature

Date

WE Fit Wellness
The Right Fit for Everyone

MEDIA RELEASE

WE Fit Wellness provides fitness programming, marketing support, and consulting services.

WE Fit Wellness often takes photographs and video of youth and adult program participants and for educational and promotional purposes. These images may be used in printed materials, on our website, and in training and promotional videos. We may also send them to the news media.

I give permission to the WE Fit Wellness and other WE Fit Wellness program partners to use my image or likeness, or those of my child(ren), in materials produced by WE Fit Wellness for promotional and educational purposes or for any other purpose and in any manner and medium.

Printed Name _____

Signature _____

Date _____

If Program Participant is UNDER 18

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

Phone _____

Child(ren) Names _____