Colorado Center for the Blind
2233 West Shepperd Avenue
Littleton, CO 80120
(303) 778-1130
ccb@cocenter.org

SUMMER PROGRAMS APPLICATION

CCB offers three summer youth programs, but space is limited. Acceptance is on a first-come, first served basis. The date that this application form, along with the student's essay, is received will be the date we will use for determining priority. All requested medical information must be completed.

The student must submit an essay of no more than 250 words explaining why you (the student applicant) would like to attend the Colorado Center for the Blind.

Send this application and the student's essay to the above address, fax to 303-778-1598 or email to **ccb@cocenter.org**

After receiving confirmation of acceptance, you will also receive a packet of releases that must be signed and returned. These will include media releases and legal releases for challenge recreation activities.

I am applying for (check one):

_____Summer for Success College Prep Program (8 weeks)
Students should have completed his or her junior year in high school with a focus on attending college after graduation from high school.

_____Earn and Learn High School Program (8 weeks)
For students 14 years of age and older who want to gain real work experience.

_____Initiation to Independence Middle School Program (3 weeks)
For students 11 to 14 years of age.

Student Information

Student's first name: _____

Student's last name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Email: _____

Date of birth: _____ Gender: _____

Cause of blindness: _____

Have you (the student) ever attended another summer program or camp? When and where?

_____

Contact for non-emergency and emergency situations:

Primary contact
Relationship to student: _____

Name: _____

Primary phone number: _____

Cell/Home/Work email address: _____

Is this person allowed to pick up student during or at completion of program? _____

Secondary Contact
Relationship to student: _____

Name: _____

Primary phone number: _____

Cell/Home/Work email address: _____

Is this person allowed to pick up student during or at completion of program? _____

Does the student applicant have a Vocational Rehabilitation Counselor?

VR Counselor's Name: _____

Phone: _____ Fax: _____
Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Educational Information

What grade are you in now: _____

Name of school: _____

Are you an English Language Learner: _____

Name of TVI: _____

Phone: _____ Fax: _____

Email: _____

Can we contact TVI: _____

Primary reading mode (check one)
Braille: _____
Standard print: _____
Large print: _____
Audio books: _____
Audio (synthesized speech): _____

Other reading modes (check all that you use)
Braille: _____
Standard print: _____
Large print: _____
Audio books: _____
Audio (synthesized speech): _____

Mobility/Travel (check all that apply)
Long white cane: _____
Dog guide: _____
No mobility device: _____
Sighted guide: _____
Other: _____

How do you (the student) take notes in school (check all that apply)?
Slate and Stylus: _____
Perkins Brailler: _____
Large print (such as a marker): _____
Standard print: _____
Braille note taking device: _____

Cell phone or tablet: _____
Laptop: _____
Other: _____

What additional technology do you (the student) use? _____

Medical Information

Secondary conditions that may require accommodations: _____

_____

Explain history of these medical conditions, serious injuries, illnesses, or hospitalizations. Please include anything you feel will be important the for the Colorado Center staff to know:

_____

Doctor's name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Health insurance Provider: _____

Policy/group number: _____ Phone: _____

Current Medications
Name of medication: _____

Medication is prescribed for: _____

Date prescribed: _____ Directions for usage: _____

Are you (the student) able to administer your medication independently, yes or no: _____
If no please explain: _____

Name of medication: _____

Medication is prescribed for: _____

Date prescribed: _____ Directions for usage: _____

Are you (the student) able to administer your medication independently, yes or no: _____

If no please explain: _____

Please list any medications you are allergic to and symptoms of your allergic reactions:

_____

Please list any food allergies you may have and describe your reaction symptoms:

_____

Other allergies: _____

Special dietary requirements: _____

Any additional information that will help us in working with you: _____

_____

Application form completed by: _____