



2233 West Shepperd Avenue, Littleton, Colorado 80120
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APPLICATION

2018 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
Media/Social Media Release Effective 3/1/16

1. I understand that I may be photographed, videotaped, recorded and/or interviewed for print, online or other distribution while a student/participant at the Colorado Center for the Blind.
2. I grant permission to the Colorado Center for the Blind to allow said video, photo, audio, 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.
3. I further grant permission for my image to be posted to social media such as Face Book, Twitter and others that may be used by the Colorado Center for the Blind and the National Federation of the Blind.

If Participant is 18 years of age or older:

_____ No, I do not grant permission for my image, likeness or voice to be shared.

_____ Yes, I give permission to the Colorado Center for the Blind and the National Federation of the Blind to use media containing my image, recorded voice, etc. as detailed above.

Participant Name (Please print): _____

Participant Signature: _____

Date: _____ Phone: _____ Email: _____

If Participant is under age 18:

_____ No, I do not grant permission for my image, likeness or voice or my child's image, likeness or voice to be shared.

Yes, I give permission to the Colorado Center for the Blind and the National Federation of the Blind to use media containing (please check all that apply):

_____ My image, recorded voice, etc. as detailed above and/or

_____ My child's image, recorded voice, etc. as detailed above

Child's name _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____ Phone: _____ Email: _____