PARTICIPANT APPLICATION

EXTENDED SCHOOL YEAR PROGRAMS 2019

Kansas Summer Expanded Education (K.S.E.E.), Vocational, and KS-PREP Programs
Kansas State School for the Blind, Kansas City, KS

SEE ATTACHED BROCHURE FOR PROGRAM DETAILS

Submit completed application by March 10, 2019. The completed application must include release forms, and the individualized education plan. Please Note: Students must be age 5 before June 1, 2019 for KSEE, and age 16 before June 1, 2019 for VOC and KS-PREP.

***The application is not complete until all forms are submitted. Applications are accepted by paper AND on-line for summer 2019. Scan all required information as an e-mail attachment to:**

Renee Wilson reneewilson@kssdb.org

For questions on the application process contact: Aundrayah Shermer, ashermer@kssdb.org , 913- 305-3016

***PLEASE INDICATE WHICH PROGRAM YOU ARE APPLYING TO:**

- ☐ **K-SEE PROGRAM: AGES 5-15**
- ☐ **VOCATIONAL PROGRAM: AGES 16-21**
- ☐ **KS - PREP PROGRAM: AGES 16-18**
- ☐ **K-SEE HAYS PROGRAM: AGES 10-15**

Please list anticipated absences and reason for K-SEE, VOC, KS-PREP, or K-SEE Hays Programs

Date(s): _____ Reason: _____

"While we understand that not all absences are avoidable, KSSB will give preferences to those students who are able to commit to the entirety of the Summer 2019 ESY program."

Participant Information

Name:_____ DOB:_____

Home Address (including city, state and zip):_____

Home Phone (including area code): _____

Participant Cell (including area code): _____

Participant E-mail: _____

Parent/Guardian Name:_____

Parent/Guardian Phone (including area code): _____

Parent/Guardian Email: _____

Participant School District: _____

Participant 2017-18 Grade: _____ Participant Graduation Year: _____

Participant TSVI/COMS:_____

Participant TSVI/COMS E-mail: _____

Participant Cause of Vision Loss: _____

Participant Visual Acuities: _____ (Right eye) _____ (Left eye) _____ (both eyes)

Please select preferred reading medium:	▢ Large Print	▢ Braille	▢ Regular Print	▢ Electronic

Does participant wear glasses? _____ YES _____NO

Does participant use a white cane? _____ YES _____NO

Does participant wear hearing aids? _____ YES _____NO

Does participant have a Cochlear Implant? _____ YES _____ NO

Emergency Contact Information

Emergency Contact Name:_____

Emergency Contact Phone:_____

Emergency Contact Name:_____

Emergency Contact Phone:_____

Participant Medical Conditions **(please list - Seizures, Diabetes, Autism, etc.):**

_____

_____

Participant Allergies **(medicines, foods, environment):**

_____

_____

Participant Special Diet Information:

_____

_____

Participant Technology Used:

_____

_____

******KSSB is not responsible for lost or stolen electronics******

Any Additional Information to be shared with Participant's Summer Education team:

_____

_____

NOTE - Application is not considered complete until KSSB receives:

- ☐ **Application (INCLUDING RESIDENTIAL SERVICES INFORMATION IF STAYING IN DORM)**
- ☐ **Individualized Education Plan (IEP, including behavior plan if applicable)**
- ☐ **ECC domain list filled out (page 4 of application)**
- ☐ **Release / Consent Forms (pages 5 and 6 of application)**
- ☐ **Health Examination Form (page 7 of application)**
- ☐ **Medication Information (pages 8 and 9 of application)**
- ☐ **Dorm Information (ONLY if participant residing in dorm, page 10 of application)**

The KSSB Summer 2019 Program will focus on the Expanded Core Curriculum domain areas listed below. Please share information about your participant for each domain. Braille reading and writing will be embedded each day throughout the summer program.

Recreation and Leisure:

_____

_____

_____

Activities of Daily Living:

_____

_____

_____

Assistive Technology:

_____

_____

_____

Orientation and Mobility:

_____

_____

_____

Social Skills/Self-Determination:

_____

_____

_____

Transition:

_____

_____

_____

Career Exploration: (Please list 3 career interest areas VOC/KS-Prep participants)

_____

_____

_____

Authorization for Treatment of Participant
And Consent, Release, and Covenant

The undersigned parent/guardian represents to the Kansas State School for the Blind that the minor named below is in his and/or her legal custody and control; and that the undersigned desires said minor to participate in the programs of the Kansas State School for the Blind and that for purposes of said participation the undersigned agrees, authorizes and states as follows:

In case of medical or dental need or emergency, I (we) understand every effort will be made to contact parents/guardians of minors. In the event I (we) cannot be reached, I (we) undersigned, parents/guardians of _____, a minor, do hereby authorize the Kansas State School for the Blind and its officers or staff employees as agent(s) for the undersigned to obtain and consent to any X-ray examination, anesthetic, medical, dental, surgical diagnosis, treatment and hospital care which is deemed advisable by, and is to be rendered to said minor under general or specific supervision of any surgeon licensed under the provision of the Medical Practice Act or the medical staff of a licensed hospital or by a dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis of treatment is rendered at the office of said physician or dentist or at the said hospital.

I (we) also understand and agree that any and all such medical, dental, hospital or similar expenses incurred in the treatment of my (our) child will be borne by myself (ourselves). We understand that no representation of such coverage exists or is intended by this form.

It is understood that this authorization is given in advance of any specific medical or dental diagnosis, treatment or care being required but is given to provide authority and power on the part of the Kansas State School for the Blind (as aforesaid) as my (our) agent(s), to give specific consent to any and all such diagnosis, treatment or care which a licensed physician or dentist in the exercise of his/her best judgment may deem available.

This authorization shall remain effective while the minor is enrolled in any Kansas State School for the Blind program, unless sooner revoked in writing and delivered.

Participant Name: _____

Parent/Guardian Name: _____

Signature (Parent/Guardian if **under** 18 years of age): _____

Date: _____

Publicity Release

I hereby authorize and give permission for the participant's name, photograph, video and/or other identifying information (such as age, eye condition, etc.) to be used by the Kansas State School for the Blind for publicity purposes. I understand such uses may include brochures, newsletters, website entries, press releases, or written stories without payment or any other compensation. I further understand some uses may be for information and material sent to other organizations/companies (newspapers, television, radio, conference presentations, etc.) and that the materials will become the property of the Kansas State School for the Blind and will not be returned. *KSSB posts photos of students/activities on Facebook. However, no student names or identifying information is posted.

Release of Information

I hereby authorize and give permission to the Kansas State School for the Blind to obtain and/or provide information to school district(s), optometrist/ophthalmologist, and/or any other educational or community work sites for programming and collaboration regarding the participant listed below.

Off-Site Activities

I hereby authorize and give permission for the participant identified below to participate in any off-site activities as a part of ESY Summer 2019 programming.

Medical Release

I certify that I am the parent or legal guardian of this child. I certify that this child has no illness, disease, condition or injury that places this child at medical risk to participate in the intensive exercise program offered through ESY. I certify that I have submitted this child to a thorough medical examination by the physician below and that I have provided a complete medical history to the physician.

In consideration for allowing my child to participate in the ESY programs, I am hereby providing a **FULL RELEASE** to Kansas State School for the Blind where the program is conducted and their respective agents, employees, officers and directors from all claims, demands, actions, judgments and executions for which the child or undersigned or their heirs, executors, administrators, guardians, conservators or assigns ever had, now has or may have in the future or claim to have.

Participant Name: _____

Parent/Guardian Name: _____

Signature (Parent/Guardian if **under** 18 years of age): _____

Date: _____

HEALTH EXAMINATION FORM

(Must complete for those participants NOT attending KSSB during the academic year)

(TO BE COMPLETED BY YOUR FAMILY MEDICAL PROFESSIONAL)

I certify that I have examined this individual and that, on the basis of the examination and the individual's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this individual to participate in a **daily swimming and exercise program**.

Participant Name: _____

Physician's Name: _____

Physician's Signature: _____

Date: _____

HEALTH INSURANCE INFORMATION

NAME OF COMPANY: _____

NAME OF POLICY HOLDER: _____

GROUP #: _____

INDIVIDUAL #:_____

MEDICAL CARD (SRS) #:_____

ESY SUMMER 2019

PRESCRIPTION MEDICATION INFORMATION

PARTICIPANT NAME: _____

*If your child requires a prescribed and/or over the counter medication to be given while staying in the dorm, please furnish the school health center with a supply that will last for the entire ESY program. State law requires that the medication be brought to school in the original container appropriately labeled by the pharmacy with the name of the medicine, correct dosage and times to be given. The pharmacist is usually happy to supply an extra labeled bottle for use at school.

Please list all medications participant will be taking during ESY program summer 2019:

Name	Dosage	Time	Comments
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

DOES YOUR CHILD HAVE A HISTORY OF SEIZURES? _____YES _____NO

IF YOUR CHILD IS FEMALE HAS SHE STARTED MENSTRUAL CYCLE? _____ YES _____NO

PLEASE INCLUDE ANY OTHER ADDITIONAL INFORMATION YOU FEEL IMPORTANT:

_____

_____

_____

THE FOLLOWING MEDICATIONS ARE CONSIDERED "OVER THE COUNTER" AND SOME ARE AVAILABLE AT THE KSSB HEALTH CENTER DURING THE ESY PROGRAM SUMMER 2019. THESE MEDICATIONS ARE ONLY GIVEN IF AGE APPROPRIATE, USUALLY AGE 12 AND UP. PLEASE INDICATE BY **DRAWING A LINE THROUGH** THOSE WHICH YOUR CHILD IS **NOT** ALLOWED TO HAVE:

Participant's Name: _____ Date:_____
Parent Signature: _____ Allergies:_____
Student Signature: _____

FEVER/PAIN CONTROL:	Ibuprofen (Advil) liquid / tablets Acetaminophen (Tylenol) liquid / tablets
COLD / COUGH ALLERGY REMEDIES:	Triaminic Syrup and Expectorant Robitussin DM / PE cough syrup Sudafed liquid / tablets / XR Mucinex XR Pseudoephedrine/Sinus Pain and Pressure Diphenhydramine
STOMACH ACHES / DIARRHEA:	Mylanta liquid / tablets Imodium AD liquid / tablets
SORE THROAT:	Warm Salt Water Gargle Chloraseptic Spray Cepacol / Halls / Sucrets throat lozenges
MOUTH SORES / TOOTH ACHES:	Kanka/Anbesol Blistex
MUSCLE ACHES:	Myoflex Ointment
INSECT BITES / STINGS:	Insect Repellant Benadryl liquid / tablets Calamine lotion Hydrocortisone cream 1%
SUNBURN:	Sunscreen Lotion Solarcaine Aloe Vera Gel
ATHLETES FOOT / FUNGAL:	Tinactin cream / powder Monistat Cream
HEAD LICE TREATMENT:	Nix Shampoo Clear (to help remove nits)
FIRST AID FOR CUTS / SCRAPES:	Hydrogen Peroxide Triple Antibiotic Ointment Medi-Quick Spray
MISCELLANEOUS:	Eucerin Cream (for dry skin) Debrox Otic drops (for ear wax) Calamine Lotion (for poison ivy)

RESIDENTIAL SERVICES INFORMATION

ONLY COMPLETE Page 10 IF PARTICIPANT IS STAYING IN THE DORM

Participant Name: _____

While staying in the KSSB Dorm for ESY Summer 2019, is anyone besides KSSB staff and you the parent allowed to visit your child or take him/her off campus?

_____YES _____ NO

IF 'YES', PLEASE GIVE THE NAME, CONTACT INFORMATION AND SPECIFY WHETHER THEY CAN VISIT, TAKE CHILD OFF CAMPUS OR BOTH.

Name: _____ Phone: _____

Visit on Campus? _____YES _____ NO Take off Campus? _____YES _____ NO

**EXTENDED SCHOOL YEAR IS AN INTENSIVE PROGRAM THAT CONTINUES BEYOND THE SCHOOL DAY FOR STUDENTS STAYING IN THE DORM. PARENTS ARE WELCOME AT ANY TIME BUT WE ASK THAT ANYONE ELSE WISHING TO VISIT YOUR CHILD WHILE AT KSSB UNDERSTAND THAT THESE REQUESTS MUST BE APPROVED IN ADVANCE BY THE ESY COORDINATOR AND MUST NOT INTERFERE WITH YOUR STUDENTS DAILY SCHEDULE.*

Is participant allowed to drink coffee, tea, soft drinks? _____YES _____ NO

List any sleep problems participant has: (EX. NON-24, SLEEP WALKER, NIGHTMARES, ECT.)

_____

_____

(Please note phones for students under age 16 are collected at bedtime)

Additional Information for Dorm Staff

Does Participant need to be awakened at night to toilet? _____ YES _____ NO

Will Participant be bringing any spending money to ESY program? _____ YES _____ NO

Is Participant able to keep track of their money independently? _____YES _____ NO

Does Participant have any behavior issues? _____YES _____NO

If 'YES', please explain: _____

_____

_____