

OHIO STATE SCHOOL FOR THE BLIND
5220 NORTH HIGH STREET
COLUMBUS, OHIO 43214
614-752-1359

BAND CAMP July 31-August 5, 2016 REGISTRATION FORM

General Information:

PARTICIPANT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ ZIP _____

PARENT'S TELEPHONE: (Home) _____ (Work) _____

EMERGENCY TELEPHONE _____

PARENT(S) NAME(S) _____

CURRENT GRADE LEVEL OF STUDENT _____

CURRENT SCHOOL INSTRUCTOR _____

CURRENT DISTRICT AND SCHOOL ATTENDING _____

CURRENT SCHOOL PHONE NUMBER _____

Health Information:

Cause of Visual Impairment or Blindness _____

Amount of Remaining Vision: Left Eye _____ Right Eye _____

Additional Disabilities: (Please explain) _____

Allergies (include reactions to specific foods): _____

Medications: _____

Behavioral Concerns: (Please explain) _____

School Information:

1. What type of technology or adaptive equipment does your child presently use?
2. What level of Braille skills does your child presently have?
3. Does your child own his/her own instrument?
4. What instrument(s) does your child play?

Mobility Information:

1. Please check one, which most closely describes your community:
 Rural Urban Suburban
2. Can your child travel independently in your neighborhood? Yes No
3. Can your child cross streets or roads independently near your home?
 Yes No
4. Please check all types of streets, roads and intersections you know your child can cross safely:
 A quiet residential street A busy residential street
 Two-way stop sign intersection Traffic light with two busy main streets
 Other: _____
5. Can your child travel at night? Yes No
6. In addition to the visual impairment, are there any special problem(s) or circumstances that prevent your child from traveling outside alone in your neighborhood? _____

7. Please check services that student has received:
- | | |
|---|--|
| <input type="checkbox"/> Vision Stimulation and/or Training | <input type="checkbox"/> Concept Development |
| <input type="checkbox"/> Sensory Training | <input type="checkbox"/> O&M Training |
| <input type="checkbox"/> Low Vision Evaluation | <input type="checkbox"/> Other _____ |
8. Are you aware of any orientation or mobility needs that the student has which are presently not being met or planned for?
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9. Please list any mobility or low vision aids that your child uses. (If equipment is owned or on loan, please bring with you to summer program).
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