ENVISION®

LEVEL UP MIDDLE SCHOOL

COVER PAGE

Dear Parents,

This is in follow up to the referral we received from your child's teacher recommending your child attend our Level Up Middle School Assistive Technology Program. Per your request, enclosed is the full Program Application.

Registration is limited. Please return the application with the registration fee within two weeks in order to reserve a place for your child. Registration will not be finalized until the application process is completed.

The total cost of the program is $100. A check for the fee is to be made out to Envision. Please memo Level Up MS Program. Financial assistance is available. If you request financial assistance, please check the request box on the application and submit your child's application as soon as possible.

You may return the application by any of the following methods:

MAIL	Attention: Hannah Christenson • Envision • Level UP Program 610 N. Main St. • Wichita, KS 67203
FAX	Hannah Christenson • (316) 440-1540
SCAN AND E-MAIL	**hannah.christenson@envisionus.com**
DROP OFF	You may drop off the application at the Envision front desk during the hours of 8 to 5, M-F • Attention: Hannah Christenson

Upon receipt of the completed application, you and your child's teacher will be notified of acceptance to the program. You will also receive the Middle School information packet.

Registration is limited. Please complete the application process immediately!
In order to avoid delays and process quickly, please complete all fields.

Please contact us if you have any questions and/or wish to further discuss the program.

Sincerely,
Bonnie Cochran, Director Support Programs, Envision Inc.
(316) 440-1510

CONNECT ENGAGE ACT

To improve the quality of life and provide inspiration and opportunity for people who are blind or visually impaired through employment, outreach, rehabilitation, education and research.

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LEVEL MIDDLE SCHOOL

May – Aug, 2020

GUARDIAN INFORMATION *(Circle One: Parent / Guardian)*

☐ $100 registration fee enclosed ☐ Request financial assistance ☐ Check in mail ☐ District pay

Name _____ (Last) _____ (First)

Email _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

EMERGENCY CONTACT *(please provide the name of someone not listed above - parent/guardian will always be tried first)*

Name: _____ Relationship: _____

Home Phone: _____ Work: _____ Cell: _____

STUDENT INFORMATION

Name _____ (Last) _____ (First) _____ (Nickname)

Street Address _____ City _____ State _____ Zip _____

Cell Phone _____ Student E-mail _____

Birthdate _____ Age _____ Current Grade Level _____ Gender _____

TSVI INFORMATION

Name _____ School _____

Email _____ Phone _____ Summer Contact _____

TECHNOLOGY INFORMATION

Student uses his/her own personal computer in the home ☐ Yes ☐ No ☐ Laptop ☐ Desktop

Student uses school computer only ☐ Yes ☐ No

Student uses email ☐ Yes ☐ No

Student has access to the Internet ☐ Yes ☐ No

Student is currently using the following assistive technology hardware: ☐ BrailleNote ☐ PAC Mate

☐ CCTV ☐ iPad ☐ BrailleSense Plus ☐ Other _____

Student is currently using the following assistive technology software : ☐ JAWS ☐ NVDA ☐ Voice Over

☐ Windows Magnifier ☐ Zoom for Mac ☐ ZoomText ☐ Magic ☐ Other _____

Student is bringing a personal computer that is equipped with the following:

☐ Microsoft Office 2013 or newer ☐ Updated Microsoft Office 365 ☐ Screen reader (e.g. NVDA or Voice Over)

☐ Antivirus software (e.g. Windows defender or AVG)

TECHNOLOGY ACCESSIBILITY USE CONTENT

During the Envision Level Up Program, students will have access to email and internet. ***(parent/guardian - please initial)***

____ I consent for my child to access and participate in instructor-moderated, Internet-based training during the Envision Level Up Program. I understand that is is my responsibility to monitor my child's usage of the internet and release Envision from any and all liability resulting from usage outside the Envision Level Up Program

VOLUNTARY SELF-IDENTIFICATION INFORMATION

Completion of this information is voluntary and is not a requirement. This information will in no way affect the decision regarding your application. This information will be kept confidential

☐ I decline to identify my race & ethnicity

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race *Select one or more values*
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other
- ☐ Pacific Islander
- ☐ White
- ☐ Two or More Races

MEDICAL INFORMATION

Student is covered by family medical/hospital insurance ☐ Yes ☐ No

If yes, indicate carrier or plan name _____ ID# _____ Group # _____

Carrier Address _____ City _____ State _____ Zip _____

Name of Insured _____ Phone _____

Primary Care Physician: Name _____ Phone _____

Mental Delay	☐ Yes	☐ No	Developmental Delay:	☐ Yes	☐ No
Aggressive Behaviors:	☐ Yes	☐ No	Physical Disability:	☐ Yes	☐ No
Psychological Impairment:	☐ Yes	☐ No	Criminal Record:	☐ Yes	☐ No

Give details _____

VISUAL INFORMATION

Optometrist/Ophthalmologist: Name _____ Phone _____

☐ Visual Disability ☐ Total ☐ Legal Blind Status ☐ Reads large print ☐ Reads Braille

Visual Diagnosis _____

Acuities _____ Field Loss _____

Visual Support:
- ☐ Daily glasses
- ☐ Readers
- ☐ Bioptic glasses
- ☐ Telescope Magnifier
- ☐ Cane use
- ☐ Guide Dog
- ☐ Contacts (circle one: right eye • left eye • both)
- ☐ Prosthesis (please explain)

Give details _____

ALL FIELDS MUST BE COMPLETED

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STUDENT LETTER OF INTENT REQUIREMENT

Dear Student,

As part of the application process, each applicant must include a letter of intent. It helps our instructors adjust the curriculum to meet your individual goals and needs. It also helps our donors understand the significant impact of this program.

This letter of intent must be written by the applying student and must follow the guidelines listed:

- Use your best writing style; it may be hand written or typed
- Include your name and the date
- Address the letter to: Level Up Committee
- The letter should be no longer than one print page in length

In preparing your letter, please address the following topics:

- Tell us about yourself: What are your hobbies?; Do you play any sports?; Do you play an instrument(s)?
- Discuss your interest in and reasons why you desire to attend the Level Up Program
- Discuss what you expect to gain from participation in the Level Up Program
- List any specific goals that you hope to accomplish
- Discuss how you expect to adapt the technology learned into your academic life, social life and/or your future career
- Top three career choices

We realize that these choices may likely change, but we are interested to know your thoughts at this time, as well as your hopes and dreams for your future.

ENVISION CONSENT AND RELEASE

As parent/guardian of the student – *(please initial each statement)*

☐ I hereby release Envision, Wichita State University, Go Baby Go, Go Create, Butler Community College, Newman University and all volunteer Level Up Program staff from any and all claims and liability arising from any injury, illness, damages or loss or destruction of personal property, which may occur as a result of my child's participation in or traveling to or from the program activities.

☐ I give my permission for me and my child to be added to The Envision Research Institute research database for future research participation opportunities.

ENVISION CONSENT TO USE NAME AND LIKENESS

THIS CONSENT TO USE NAME AND LIKENESS given by:

By signing below, I _____ grant unto ENVISION, INC. and its subsidiaries and affiliates (the "Grantee"), their successors and assigns, the right to take, use, and publish for advertising, commercial, and other lawful purposes, the photographic portraits, photographic likenesses, pictures and sound recordings of Grantor (the "Rights"), including, without limitation, portraits, photographic likenesses, pictures and sound recordings created by Grantee in whole or in part, in composite or other form, in conjunction with Grantor's own or a fictitious name, and in all forms and media now known or hereafter created, including but not limited to motion pictures, video recordings and tapes, and print advertisements. The grant by Grantor to Grantee of such Rights to be perpetual and without additional consideration and compensation.

Grantor waives any right that Grantor may have to inspect or approve the finished product or the advertising or other copy that may be used in connection therewith or the use to which it may be applied.
Grantor releases and discharges Grantee and the photographer, director, video technicians or other employees or agents of Grantee, their successors and assigns and all persons acting under their permission or authority, from any liability by virtue of any blurring, distortion, alteration, effects or use in composite form whether inten-tional or otherwise, that may occur or be produced in the taking of the pictures, recording of the sounds, or in any processing tending toward the completion of the finished product.

Grantor/Parent or Guardian Signature: _____ Date: _____

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LEVEL MIDDLE SCHOOL

MEDICAL HISTORY REQUIRED

May - Aug 2020 — FAX: (316) 440-1540

Student Name: _____

Physician's Name: _____ Phone Number: _____

ALLERGIES

Medication: _____

Reaction: _____

Food: _____

Reaction: _____

Other to include: insect stings, bee stings, hay fever, animal dander, etc...

_____

Reaction: _____

IMMUNIZATION HISTORY

All immunizations must be up to date. Give date of last boosters

Your child's current school health record will suffice and can be submitted with this form

DPT: _____ Polio OPV (Sabin): _____

Measles _____ Tetanus: _____

Mumps: _____ Tuberculin Test: _____

Medical Personnel Signature _____ Date: _____

In case of medical emergency, I grant permission for my child to receive medical treatment.

Parent or Guardian Signature _____ Date _____

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HEALTH ASSESSMENT

Please check the boxes that apply to your Child

If you ***answer YES*** to any questions below, please explain and add additional comments on a separate page if necessary.

		YES	NO
1.	Was child born blind? If no, at what age? _____	☐	☐
2.	Have diabetes?	☐	☐
3.	Have asthma?	☐	☐
4.	History of seizures?	☐	☐
5.	History of heart problems?	☐	☐
6.	Have a hearing impairment? If yes, wear a hearing aid?	☐	☐
7.	Have an orthodontic/orthopedic appliance? (circle)	☐	☐
8.	Have problems with diarrhea/constipation?	☐	☐
9.	History of heartburn or other stomach problems?	☐	☐
10.	Have frequent headaches?	☐	☐
11.	Have frequent ear infections?	☐	☐
12.	Gets sick or dizzy following physical activity?	☐	☐
13.	Have problems with joints?	☐	☐
14.	Have any skin problems?	☐	☐
15.	Have a chronic/recurring illness or condition?	☐	☐
16.	Have problems with sleepwalking/sleeping? (circle)	☐	☐
17.	Have bed wetting/incontinence?	☐	☐
18.	Have an eating disorder?	☐	☐
19.	Afraid of the dark?	☐	☐
20.	Has successfully stayed away from home over night?	☐	☐
21.	Performs personal activities unassisted? (dressing, showering, feminie hygiene, grooming, etc.)	☐	☐

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ENVISION FAX: (316) 440-1540

REQUEST TO ADMINISTER MEDICATION

Medication is administered during youth events only upon written request from both a parent or lawful custodian and a licensed physician or dentist. Guidelines for Medication Administration can be found through the National Association of School Nurses.
www.nasn.org/nasn/advocacy/professional-practice-documents/position-statements/ps-medication#

Parents, please provide the following information:

Name of Youth: _____ Birth Date: _____

I certify that the child named above has received at least one dose of the medication requested below and has not had adverse reactions to it. I agree to the procedures outlined in the Guidelines for Medication Administration. I authorize appropriate program staff and/or nurse to exchange information regarding this medication request with the health care provider(s) listed below and with the dispensing pharmacy identified on the medication label.

Date: _____ Signature: _____
Parent or Legal Custodian

Home Phone _____ Cell Phone _____ Work Phone _____

Physician, please provide the following information for each medication:

Printed Name of Physician/ARNP/PA _____

Office Phone #_____ Office Fax #_____

1. _____ needs to receive the following medication during day time hours for the diagnosis of _____.

Medication: _____ **Dosage Amount:** _____

Time: _____ Other directions for administering: _____

Date: _____ Signature: _____
Physician/ARNP/PA

_____
Supervising Physician (required for ARNP or PA)

JAN 2020

2._____ needs to receive the following medication during day time hours for the diagnosis of _____ .

Medication: _____ Dosage Amount: _____

Time: _____ Other directions for administering:_____

Date:_____ Signature: _____
Physician/ARNP/PA

_____
Supervising Physician (required for ARNP or PA)

3._____ needs to receive the following medication during day time hours for the diagnosis of _____ .

Medication: _____ Dosage Amount: _____

Time: _____ Other directions for administering: _____

Date:_____ Signature: _____
Physician/ARNP/PA

_____
Supervising Physician (required for ARNP or PA)

4._____ needs to receive the following medication during day time hours for the diagnosis of _____ .

Medication: _____ Dosage Amount: _____

Time: _____ Other directions for administering: _____

Date:_____ Signature: _____
Physician/ARNP/PA

_____
Supervising Physician (required for ARNP or PA)

5._____ needs to receive the following medication during day time hours for the diagnosis of _____ .

Medication: _____ Dosage Amount: _____

Time: _____ Other directions for administering: _____

Date:_____ Signature: _____
Physician/ARNP/PA

_____
Supervising Physician (required for ARNP or PA)