Initial Program Registration 2018-19

Student Name: ____ **DOB:** ________________
Last *First* *preferred name*

Student Gender_________________________ **Ethnicity/Race**____________________________

Address:____
Street **Apt**

____
City **State** **Zip** **County**

Parent/Guardian 1
Name:____

Email:________________________________ **Phone:**_____________________________________

Parent/Guardian 2
Name:____

Email:____ **Phone:**____________________________

Emergency Contact (other than Parent / Guardian)
Name:____

Email:____ **Phone:**____________________________

Center for the Visually Impaired, STARS Program
739 West Peachtree Street NW, Atlanta, GA 30308
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Student Name: ____

Total number of people living in the household: _________________________________

Total Annual Gross Household Income (CONFIDENTIAL for Funding Sources Only)

___ Under 11,200 ___ 11,201-15,100 ___ 15,101-19,000 ___ 19,001-23,000
___ 23,001-26,900 ___ 26,901-30,800 ___ 30,801-38,700 ___ 38,701-41,700
___ 41,700-44,700 ___ 44,701-47,770 ___ 47,771-50,000 ___ 50,001-100,000
___100,001-250,000 ___ 250,001-500,000 ___ 500,000+

Primary Visual Diagnosis: ____

Secondary Visual Diagnosis:____

Other Medical Diagnoses:____

Allergies:____

Medications:____

Please mark the STARS Activities that your family would be interested in:

____ After School Program
____ Summer Enrichment Program
____ Mentoring Program
____ Weekend Social/Recreational Activities
____ Georgia Blind Sports Association sponsored events

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School / Education Information

Student Name: ____

School: ____

County: ____________________ **Grade:** ____________________

Diploma Track:

- ☐ Regular Diploma
- ☐ IEP Diploma
- ☐ Other ______________________________

Does the student have an IEP? ☐ Yes ☐ No

Does the student have a 504?: ☐ Yes ☐ No

Has the student graduated high school? ☐ Yes ☐ No

What are the student's post high school plans?

____

____

____

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Registration Fee

I understand all families in the STARS program are expected to contribute financial support toward their participation in the program. The Center for the Visually Impaired is the only comprehensive, accredited, non-profit agency in the state of Georgia that provides comprehensive services to those impacted by vision loss across the entire life span. All financial contributions to our agency go directly into our programming and services.

The registration fee provides a year of access to:

- The STARS e-newsletter
- Invitations to family events and parties
- Invitations to outings

Student's Name: ____

Please select one of the following payment options:

☐ **A one-time payment of $100.**
(Additional donations can be made to CVI for the STARS program.)

☐ **Four monthly payments of $25 to equal a total of $100.**
Credit cards are charged the first Wednesday of each month, until the above total is paid. The monthly payment option is only available via credit cards. Cash or checks cannot be accepted for the monthly payment option.

Method of Payment:

☐ Cash
☐ Check made out to CVI with "STARS Registration" in the memo section
☐ Visa
☐ MasterCard

Credit Card Number ________________________________

Expiration Month _______ Year _______

Name as it appears on card ____________________________

Signature ___________________________________

Date _______

Office use
House number: Zip:

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Student Name: ____

Licensing
STARS (Social, Therapeutic, Academic and Recreational Services) is an educational, recreational, and social skills program for youth ages 5-21 who are blind or visually impaired. **STARS Weekend Activities** include age-specific weekend events such as indoor and outdoor recreational activities, cultural field trips, social gatherings, service projects and overnight retreats.

I hereby acknowledge that I have been advised and understand that the **STARS Activities** program my child is participating in at the Center for the Visually Impaired is neither licensed nor required to be licensed by the Georgia Department of Early Care and Learning.

Signature: _________________________ Date: _______________
(Parent/Guardian)

By signing below, you acknowledge that you have fully read and completed this application in its entirety, and that all information is accurate.

Signature: _________________________ Date: _______________
(Parent/Guardian)

Please bring this form to your intake appointment and sign the liability, photography and information releases (next pages) during your appointment so that you may discuss any questions or concerns.

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Liability Release

I give permission for ________________________________ to participate in activities and field trips with the STARS Program at Center for the Visually Impaired. I, the undersigned, agree to hold harmless the Center for the Visually Impaired, its employees, volunteers and other agents involved, from any and all injury or liability of any nature. In case of emergency, if I cannot be directly reached, I give permission for one of their representatives to sign any necessary emergency medical treatment forms in my absence.

____ ______________________

(Signature of Parent/Guardian) (Date)

Media Release

I give permission for photographs (videos, media coverage) to be taken of ______________________________ as a participant in the STARS Program to be used by the Center for the Visually Impaired in promoting and publicizing this program and/or its other activities, and for legitimate purposes.

____________________________________ ___________________________

(Signature of Parent/Guardian) (Date)

To be completed by CVI Staff Member

Date of Intake: ____________________________________

Referred by:______________________________________**Date:**_______________

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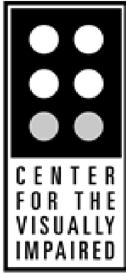

AUTHORIZATION
TO RELEASE INFORMATION

Child's Name ____

Date of Birth ____

Eye Doctor and Location of Office

____
Eye Doctor Name Office & Location

Teacher of the Visually Impaired and Contact Info

____
Teacher Name Email Phone

I hereby agree and consent for any agency that has information of a medical, social, educational or psychological nature concerning my child's condition to release this information to the Center for the Visually Impaired (CVI). I also agree and consent for CVI to, in turn, release information concerning my child that is of a medical, social, educational and/or psychological nature as needed by other cooperating agencies. Material released may or may not contain information related to infectious disease status. All information will be used only by professional persons for the purpose of aiding my child's education.

I give my permission for the Center for the Visually Impaired to assess my child for program eligibility using assessment instruments appropriate for a child with visual impairment.

Print Parent/Guardian Name ________________________________

Parent/Guardian Signature ________________________________

Date ____________________________

Witness ____

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