STARS Registration Form 2017-18

Student Name: ______________________________________ **DOB:** _______________
Last *First* *preferred name*

Student Gender_____________________ **Ethnicity/Race**________________________

Address:____
Street **Apt**

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

School: ____

County: _____________________________ **Grade:** __________________________

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
Telephone 404-875-9011; Fax: 404-602-4332; Email stars@cviga.org
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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 (Grades K-5)
_____ Saturday Academy (Grades 6-12)
_____ Summer Camp
_____ Mentoring Program
_____ Weekend Social/Recreational Activities
_____ Georgia Blind Sports Association sponsored events

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Registration Fee

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.

☐ **My family would like to apply for a scholarship** that will be applied to the registration fee. (Please complete the Scholarship Application on the next page.)

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 _______

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Scholarship Application

Scholarships are awarded based on financial need. The information you are giving is held in strictest confidence and will not be made available to anyone other than those involved with the finances of the Center for the Visually Impaired.

Student's Name: ____

Parent/Guardian's Name(s): _________________________________

Additional financial information you'd like us to take into consideration in your request for a scholarship:

I am requesting a scholarship and will pay the amount written below as evidence of my support for the STARS program. This amount will be credited toward the $100 registration fee.

Signature ____

☐ **A one-time payment of $________.**

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 __________________________________

Date ________

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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)

Photography 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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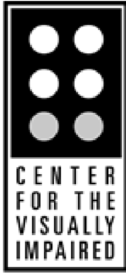

AUTHORIZATION TO RELEASE INFORMATION

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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