



Hello STARS Parents!

Registration for the 2017-18 STARS Saturday Academy at CVI is now officially open.

The program will run on Saturdays from 10:00 a.m. to 2:00 p.m. on these dates:

- | | | |
|-----------------------|----------------------|-------------------|
| 1. September 16, 2017 | 4. January 20, 2018 | 7. April 21, 2018 |
| 2. October 21, 2017 | 5. February 17, 2018 | 8. May 19, 2018 |
| 3. November 18, 2017 | 6. March 17, 2018 | |

We are respectfully asking for a registration fee of \$350 for Saturday Academy. The comprehensive services provided annually through the STARS Program average \$5,000 per year per student. **Please do not let cost keep you from participating in STARS.** Consider thoughtfully the value of service you receive and what you can afford to pay. Thanks to a continued grant from Department of Human Services, Division of Family and Children Services, we are able to offer financial assistance and you may request it on the attached registration form.

Registration will not be considered complete until all necessary documents are turned in. Upon completion, you will receive a registration confirmation via email.

Check List

1. ___ Completed Registration Form
2. ___ Most current IEP
3. ___ Payment / Scholarship Request

Materials can be addressed to the attention of STARS Saturday Academy and sent via:

- Mail: Center for the Visually Impaired, 739 West Peachtree Street NW, Atlanta, GA, 30308
- Fax: 404.602.4332
- Email: khawkins@cviga.org

The registration deadline is Thursday, August 31st. Incomplete registrations will go on a wait list after this date.

Sincerely,

Stephanie Pizza, Ed.S, TVI
Interim Director of Children & Youth Services



Saturday Academy Registration 2017-2018

Student's Name: _____ Date of Birth: _____

Parent/Guardian Name(s): _____

Address: _____

City, State & Zip: _____

Phone: (H) _____ (C) _____

Email Address(es): _____

Emergency Contact Info: _____

Student's Grade Level: _____

Name of School: _____ School County: _____

School Address: _____

City, State & Zip: _____

Vision Teacher: _____

Vision Teacher Phone: _____

Vision Teacher Email: _____

Student's Allergies / Medications: _____

I give consent for the STARS team at Center for the Visually Impaired (CVI) to share my child's program related information with teachers and school officials that have interest in my education. I also authorize any school official that has information concerning my child's education to release this information to STARS staff. All information will only be used by professional persons for the purpose of transportation and education for my child's participation in the STARS Program.

Parent/Guardian Signature: _____ Date: _____



Center for the Visually Impaired
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Tel: 404-875-9011 • Fax: 404-602-4332

www.cviga.org





Saturday Academy Registration 2017-2018

Program Participation Contract

By signing below, you agree to the following:

- Regular attendance is a high priority for Saturday Academy. When you anticipate an absence, please call Calvin Lee (404.602.4373) or Stephanie Pizza (404.602.4331) or email stars@cviga.org by 9 a.m. on the day of absence. Failure to do so will be considered an unexcused absence. More than three unexcused absences will jeopardize your student's continued participation in the program.
- The focus of Saturday Academy is to enhance skills and concepts specific to the Expanded Core Curriculum that students receive in school. We realize that help with homework is also important for our students. We continue to offer assistance, especially in Braille, but it will not be the focus during program.

We understand the responsibilities of participation in Saturday Academy and agree to keep up with our responsibilities in order to receive the full value and benefit of the STARS Program.

(Signature of Parent/Guardian)

(Signature of Student)

(Date)

Media Release

I give permission for photographs, videos, and media coverage to be taken of my child, (name) _____, 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)



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STARS Saturday Academy Registration 2017-2018

Registration Fee

The registration fee includes 8 days of supplemental ECC instruction (once per month), ongoing assessment of VI-related skills and needs, individualized support, and opportunities to enhance social skills.

Student's Name: _____

Please select one of the following payment options:

- A one-time payment of \$350.**
(Additional donations can be made to CVI for the STARS program.)
- Eight monthly payments of \$43.75 to equal a total of \$350.**
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.)
- My family is eligible under the Department of Human Services, Division of Family and Children Services After School Care Program**
New DHS forms for the 2017-18 year will be sent in September / October.

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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House number:

Office use
Zip:



Saturday Academy Registration 2017-2018

Scholarship Application 2017-2018

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): _____

Number of persons in your household: _____

Your family's estimated annual income: _____

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 \$350 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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House number:

Office use
Zip:



STARS Saturday Academy Registration 2017-2018

Student's Name: _____

Department of Family and Children Services Release

STARS is an educational, recreational, and social skills program for youth ages 5-21 who are blind or visually impaired. The **STARS Saturday Academy** meets one day per month from September through May, with a break in December.

Saturday Academy students will participate in activities and instruction which target the key areas of the Expanded Core Curriculum (ECC). The ECC is a research-based, specially designed body of knowledge and skills designed to increase access, achievement and independence for youth with visual impairment and blindness, in the school setting as well as in life. Saturday Academy classes can include Literacy (Braille, reading, writing, listening); Activities of Daily Living (kitchen safety and food preparation, self-care and hygiene); Social Skills; Exercise and Health; Assistive Technology; Music; Art; and Support Group.

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

(Signature of Parent/Guardian)

(Date)



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AUTHORIZATION TO RELEASE INFORMATION

Child's Name _____

Date of Birth _____

Eye Doctor and Location of Office

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.

Print Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

Witness _____

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