To sign up your child for the __2016 SUMMER PROGRAM__, complete and return this form by April 10, 2016 to Dawn LaMee with the following items:
Daily Living Skills Checklist, Medical Form, IEP/504 Plan, and Evaluations/Progress Reports

Dawn LaMee, Liaison for Services
SD School for the Blind and Visually Impaired
423 17th Ave. SE
Aberdeen SD 57401-7699

Please check the week(s) your child will be attending.

______ **__Week 1__**: June 5-10 ______ **__Week 2__**: June 13-17 ______ **__Week 3__**: June 20-24

______ **__Week 4__**: July 10-15 ______ **__Week 5__**: July 18-22 ______ **__Week 6__**: July 25-29

Student's Name: ____ Date of Birth: __________________

Parent's Name: ____

Address: ____ Phone: _______________________

City/State/Zip: ____

School District: ____ Phone:_______________________

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To help us plan your child's program, please check specific __areas of need__. (mark all that apply)

____ Assistive Technology
___ Career Education
___ Compensatory Academic Skills
___ Independent Living Skills
____ Orientation and Mobility
___ Recreation and Leisure Skills
____ Self-Determination Skills
____ Sensory Efficiency Skills
___ Social Interaction Skills

Does your child read ____ "Print" or ____ "Braille"? (please check one)

SDSBVI Daily Living Skills Checklist

Please place an "x" in the box as it applies to your child

Name: ____________________________________ **Date of Birth:** ______________ **Date**: _____________

Can your child	**Yes**	**No**	**Some times**	**Comments**
Dress/undress self?				
Button clothing?				
Zip clothing?				
Snap clothing?				
Bathe/shower independently?				
Shampoo hair independently?				
Wash body independently?				
Place toothpaste on brush?				
Brush teeth independently?				
Toilet independently?				
Chew food well?				
Cut foods with a knife/fork?				
Use a plate guard?				
Use adaptive silverware?				
Pour liquids?				
Use a napkin?				
Make a bed?				
Tell time?				
Use an alarm clock?				
Enjoy socializing?				
Prefer to be alone?				
Enjoy outside activities?				
Swim?				
Ride a bike?				
Listen to music?				
Play video games?				
Enjoy camping?				
Read/listen to books?				
Crafts?				
Use a phone?				
Know address/phone number?				

Summer School Medical Form

Student's Name_______________________________________ DOB___________________

Insurance Company Name________________________ Insurance Number______________

Medicaid Number_______________________________

Mother's Contact Numbers
Home __________________ Work _______________________ Cell ___________________

Father's Contact Numbers
Home __________________ Work _______________________ Cell ___________________

Allergies (Medications and food):____

____

Please list all medications, dosages, and time. Please list all special treatments and time:

1______________________________ 2_______________________________

3______________________________ 4_______________________________

5______________________________ 6_______________________________

If the student has a seizure disorder, please give date of last seizure: ___________________

Brief scenario of pertinent health history regarding your child: _________________________

____

____

____

Physician's Name and Phone Number: ____

A copy of your child's immunization record must accompany this form.

Thank you
Doris Anderson, RN
SDSBVI School Nurse