Keys to Work Residential Transition Institute Application

ALL spots will be filled on a first come, first served basis.

Thank you for your interest in our exciting transition services program! Our one-of-a- kind Keys to Work Residential Transition Institute in the Oklahoma City metro area provides individualized assessments and goal setting for participants with a primary disability of vision impairment or blindness, aged 16 to 22 years old during a two-week long, residential summer program. We proudly provide comprehensive services by a Teachers of the Visually Impaired (TVI), Orientation and Mobility instructors (O&M), Occupational Therapists (OTs), Certified Occupational Therapy Assistant (COTA), and Assistive Technology Professionals (ATPs).

One of the many strengths of our program includes committed community partners as well as goals set specifically for the participants' needs and realistic expectations for effective and positive outcomes. Additionally, curriculum is tailored to individuals with vision impairments or blindness and emphasizes employment and/or college readiness skills.

Cancellations within 3 weeks prior to the start date of the program will result in a fee for all nonrefundable costs such as hotel expenses and program materials.

NewView Oklahoma reserves the right to cancel Keys to Work for any reason at any time. Please watch website and social media for updates.

Please complete the following application and return to NewView Oklahoma.

Please type or print LEGIBLY using blue or black ink.

First Name: Last Name:

Male Female Other Birthdate:

Age: Parent/Guardian Name:

Street Address: City:

State: Zip Code:

Phone Numbers: Cell: Home:

Work:

Email:

Emergency Contacts

1. Full Name: Relationship:

   Cell Phone: Second Phone:

   Email:

2. Full Name: Relationship:

   Cell Phone: Second Phone:

   Email:

3. Full Name: Relationship:

   Cell Phone: Second Phone:

   Email:

Medical Information

A COPY OF YOUR CURRENT INSURANCE CARD MUST ACCOMPANY THIS FORM

Medical/Health Issues: ◯ No ◯ Yes If yes, please describe.

Please attach and provide a doctor's list of all medications participant is currently taking or is PRN.

You may also write in below:

Allergies (including medications and food, etc.):

Visual diagnosis:

Date of last low vision examination:

Secondary disability/s:

Cognitive delays: ◯ No ◯ Yes If yes, please describe.

Additional Information

Behavioral Issues: ◯ No ◯ Yes If yes, please describe.

Does participant get homesick? ◯ No ◯ Yes

Does participant require large print or Braille? ◯ Large Print ◯ Braille ◯ Other

Is participant able to walk independently? ◯ No ◯ Yes

If not, does participant require a wheelchair, walker, or physical assistance? ◯ No ◯ Yes

If yes, what type?

Is participant receiving any additional therapies currently? School and/or outside private clinics/home therapy? ◯ No ◯ Yes If yes, please describe.

Does participant currently use technology to help complete daily tasks? ◯ No ◯ Yes

If so, please list ALL technology used and what tasks participant completes with said technology. (e.g. JAWS for reading emails, voiceover on phone, etc.)

Please list 2 goals that the PARTICIPANT would like to achieve during the program.

1.

2.

Please list 2 goals that the PARTICIPANTS FAMILY would like for you to achieve during the program.

1.

2.

Please complete attached release for permission to communicate with these agencies/therapists

School Information

Is participant receiving visual services or orientation and mobility services in their local school?

○ No ○ Yes If so, please list the provider's names:

Name of school: School address:

City: Zip Code:

Contact name for special education teacher:

Phone Number:

PLEASE ATTACH A COPY OF THE FOLLOWING:

If you are in school, please attach your most RECENT individualized Education Plan (IEP) established by school team.

If you are in college, please attach a recent accommodations list that you and your disability coordinator have established.

If you are working with Department of Rehab Services (DRS), please attach a recent IPE Plan of Employment that you and your rehab counselor have established.

Caseworker name: Phone number:

Email: Case number:

Contact information of additional service provider, including name and phone number:

Name: Phone number:

Organization/Company:

Waivers and Forms

Transition Services Permission and Liability:

I grant permission for participant, [ ] (insert name of participant), to participate in all transition services activities. I will not hold NewView Oklahoma, any of its leaders, staff, volunteers, or partner organizations providing services responsible for any accident which may occur as a result of my participant's full engagement and participation.

Name of Parent or Guardian (PRINTED): [ ] Date: [ ]

Signature of Parent or Guardian: [ ] Date: [ ]

Photo Release:

I, [ ] (insert parent/guardian name), hereby grant NewView Oklahoma and any of its partners permission and authorization to use my participant's photograph and/or story on promotional and informational materials. I understand that photos and/or information may be used in materials including but not limited to newsletters, annual reports, newspaper articles, brochures, websites, blogs and social media. I understand my participant's information and/or photograph may be copyrighted, published and/or reproduced in color or otherwise in any media at NewView Oklahoma or elsewhere. I agree that all rights to the picture belong to NewView Oklahoma and waive the right to inspect and/or approve the finished product.

Further, I am aware that I will not be compensated for any pictures or stories in which my participant may appear.

Date: [ ]

Parent/Guardian's name (PRINTED): [ ]

Signature: [ ]

☐ Check here ONLY IF you would NOT like participants name identified in association with a picture and related information.

Medical Waiver/Emergency Care:

I, the undersigned parent or person having legal custody of [ ] (insert name of participant), DO HEREBY AUTHORIZE the person(s) designated as sponsor(s) for the program in which the above named minor is participating, to initiate and provide for any medical examination, anesthetic, medical, surgical, x ray, or dental diagnosis or treatment and/or hospital care to be performed to the above named minor under general or special supervision and upon the advice of a physician. I authorize a physician, surgeon, dentist, or other licensed medical practitioner to exercise his or her professional judgment regarding care and perform such treatment as he or she, in his or her best professional judgment, determines to be necessary for the health or safety of the above-named minor.

I authorize NewView Oklahoma staff to arrange for and grant authorization to appropriate medical authorities for health care as he/she deems necessary for the well-being of my participant.

I understand that I am responsible for all costs related to medical care regardless of the status of health insurance benefit coverage.

Participant's Full Name (PRINTED): [ ]

Parent/Guardian Name (PRINTED): [ ]

Signature of Parent/Guardian: [ ]

Date: [ ]