State of Illinois
Department of Human Services

2013 OPENING DOORS APPLICATION - ILLINOIS SCHOOL FOR THE VISUALLY IMPAIRED

Child's Last Name: _____ First: _____ Middle: _____

Parent's Mailing Name: ☐ Miss ☐ Mrs. ☐ Ms. ☐ Mr. _____

Street Address: _____ City: _____ , IL Zip: _____

Phone: (h) _____ Phone: (c) _____ Phone: (w) _____ ☐ Male ☐ Female

County: _____ Date of Birth: _____ E-mail address: _____

Mobility (Check applicable descriptions):

☐ Walks ☐ Crawls ☐ Uses Wheelchair ☐ Uses Cane/Precane ☐ Other _____

VERY IMPORTANT - Briefly describe any pre-school or educational services the child is currently receiving. **Provide Reports - Required e.g. Eye Doctor Report, Functional Vision Report, OT, RT, Speech, Nutritional, etc.**

_____

_____

_____

_____

List the **name** and **Social Security Number** of the attendee above who will receive the stipend reimbursement. This is necessary for the State of Illinois to cut a check for this reimbursement.

Driver's Name: _____ **Driver's Soc. Sec. Number:** _____ - _____ - _____

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List of Attendees

☐ **Parent or** ☐ **Guardian (check one):**

Last Name: _____ First Name: _____

Street Address: _____ Home Phone: _____ / _____

City: _____ , IL Zip: _____ Work Phone: _____ / _____

Cell Phone: _____ / _____ Relationship to Child: _____

☐ **Parent or** ☐ **Guardian (check one):**

Last Name: _____ First Name: _____

Street Address: _____ Home Phone: _____ / _____

City: _____ , IL Zip: _____ Work Phone: _____ / _____

Cell Phone: _____ / _____ Relationship to Child: _____

Other Attendees:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Siblings:

Name: _____ DOB: _____ Gender: _____

LIST THOSE INDIVIDUALS WHO ARE YOUR **EMERGENCY CONTACTS** (not attending the Institute)

Relationship: _____

Last Name: _____ First Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: (h) _____ / _____ Phone: (w) _____ / _____ Phone: (c) _____ / _____ Phone: (f) _____ / _____

Accommodations:

_____ I need an American Sign Language interpreter

_____ I need a Foreign Language interpreter _____ (language)

_____ Other

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Please provide any additional information you would like to share.

SIGNATURE OF PARENT or GUARDIAN

I understand that I remain responsible for administering and routine medications my child takes during Opening Doors. I also agree that I am financially responsible for any medical treatment my child may require while attending Opening Doors.

Signed: _____ Date: _____

Please attach copies of any eye report and/or medical/educational evaluations available.

Return this applications by April15, 2013 to:

Gail Olson
Hearing & Vision Early Intervention Outreach
125 S. Webster Ave.
Jacksonville, IL 62650
Phone: 217-479-4320
Fax: 217-479-4328

I learned about Opening Doors from:

_____ Ophthalmologist
_____ Family Physician
_____ Another Parent
_____ Early Intervention Therapist _____
_____ Special Education District _____
_____ ISVI Website
_____

Other _____