CVRP
Children's Vision Rehabilitation Program

Bringing comprehensive rehabilitation services to West Virginia children with low vision

Dear Students, Parents and Teachers,

Plans are underway for our **2019 Annual Overnight Summer Institute** for teenagers. This camp is intended for visually impaired students 8th -12th grade. The target population is visually impaired on an academic track that needs reinforcement in blind specific skills such as independent living, improving confidence and socialization. The students must be independent in the areas of mobilization.

The camp will be held in Fayetteville, WV from June 4 – 6, 2019 (Tuesday – Thursday). Drop off time is from 10 am -11 am Tuesday and pick up is 2:30 pm Thursday. You will need to provide you own transportation to and from the camp. Once you register, you will receive a letter with further details.

To sign up for a camp, please complete the application and return with all signed forms to: Paula Lang, WVU Eye Institute, CVRP, P.O. Box 9193, Morgantown, WV 26506 or via email at langp@wvumedicine.org by May 3, 2019. Hurry! Spaces are limited!

Sincerely,

Becky Coakley Paula Lang

SUMMER INSTITUTE APPLICATION

Ready, Set, Go! Camp: June 4 - 6, 2019 - Fayetteville, WV

Camper's Name:_____ Birth Date: _____

Parent/Guardian:_____ Email:_____

Address: _____ Phone: (H) _____

_____ (W)_____

County:_____ (C) _____

Does your child have an open case with WV Division of Rehabilitation? □ Yes □ No SSN: _____

Visual Condition: _____

Does the camper have physical restrictions due to visual condition (i.e. fragile retina) ☐ yes ☐ no If yes, please explain

_____

_____

Please check if your child requires Braille or Large Print: ☐ Braille ☐ Large Print

Camper's grade for the upcoming school year: _____

Name of School camper currently attends: _____

Name of Vision Impairment Teacher: _____

Does your child need reinforcement in the following areas:

☐ Braille ☐ Abacus ☐ Activities of Daily Living Cooking ☐ Technology ☐ Recreation

☐ Orientation & Mobility ☐ Low Vision Devices

Please check what size T-shirt the camper wears: Adult ☐ XL ☐ L ☐ M ☐ S Child ☐ L ☐ M ☐ S

Does the camper have any physical or medical conditions requiring special care and/or attention? (Seizure disorder, asthma, food allergy, bee sting allergy, etc.,) ☐ yes ☐ no Please be specific:_____

_____

Is the camper on any medications? ☐ yes ☐ No If yes, what?_____

_____

If your child needs to take medication at camp, It must be received in its original container listing your child's name, doctor's name, the medication and correct instructions for administration of the medication.

In case of emergency, please list two emergency contacts:

Name:_____ Name:_____

Address: _____ Address:_____

_____ _____

Phone:_____ Phone:_____

Would you allow CVRP to photograph and/or videotape your child and possibly be used in future publications by CVRP?

☐ Yes ☐ No

_____ _____

Name (Signature) Date

Spaces are limited! Return all forms by May 3, 2019 to:

Paula Lang, WVU EYE Institute, PO Box 9193, Morgantown, WV 26501, fax 304-598-6928, email langp@wvumedicine.org

UHA - WVU Eye Institute

Children's Vision Rehabilitation Program

SUMMER INSTITUTE

ACKNOWLEDGEMENT OF RISK, WAIVER AND RELEASE

My son/daughter, _____ has my permission to participate in the WVU Eye Institute Children's Vision Rehabilitation Project Summer Institute ("Summer Institute"). I certify that my child is in good health and that he/she has no physical or psychological limitations which would preclude participation in the Summer Institute.

I understand that although the Summer Institute staff has taken proper precautions to provide the necessary organization, supervision, instruction, and equipment for all activities, it is impossible to guarantee absolute safety from harm. I understand and acknowledge that participation in the Summer Institute and its activities, including activities under the control of outside, third-party entities, are potentially hazardous activities and involve risks, inherent and otherwise, that cannot be eliminated and may cause injury, illness, or death to participants, including my child, and/or damage to property. I agree that I have examined the risks of participation carefully and agree to assume and accept all risks of harm to my child, and to permit my child to participate in the Summer Institute.

I further understand that in the case of a medical emergency, every attempt will be made to contact me before medical action is taken. However, this document is my consent as parent or guardian for any and all emergency treatment and/or procedures necessary for my child by the Summer Institute professional staff, including evacuation, if necessary. In addition, I understand I will be personally responsible for any medical and evacuation fees incurred.

In consideration for my child's participation in the Summer Institute, I, for myself, my heirs, assigns, spouse, next of kin, legal representatives, and administrators, and as the legal representative of my child so participating, do hereby voluntarily, fully and forever, release, waive, and discharge, West Virginia University Medical Corporation dba UHA – WVU Eye Institute, West Virginia University Hospitals, Inc., and West Virginia University, together with their members, directors, officers, agents, employees, agents, volunteers, and representatives ("Releasees") from any and all actions, claims or demands, that I, and my child, our heirs, next of kin, spouse, and legal representatives, now have, or may have in the future for injury, death, or property damage arising from or related to : (1) my child's participation in the Summer Institute, (2) negligence of other participants of the Summer Institute, or (3) the premises of Releasees upon which the Summer Institute is conducted. I also agree that my/our heirs, assignees, spouse, next of kin, and representatives, will not make claim against, sue or attach the property of any Releasee in connection with any of the foregoing matters. I understand that my child's participation is voluntary and I assume all responsibility and risk associated with his/her participation.

I HAVE READ THIS RELEASE AND WAIVER AND UNDERSTAND ITS CONTENTS, AND I ENTER INTO IT IN MY OWN FREE WILL WITHOUT UNDUE INFLUENCE. I AM AT LEAST EIGHTEEN (18) YEARS OF AGE AND COMPETENT TO EXECUTE THIS RELEASE AND WAIVER. IF I AM NOT AT LEAST EIGHTEEN (18) YEARS OF AGE, THIS RELEASE AND WAVIER IS SIGNED ON MY BEHALF BY MY PARTENT OR LEGAL GUARDIAN.

Name of Child:_____DOB_____

Name of Parent/Guardian:_____

Address:_____

Telephone:_____

Signature (Parent/Guardian)_____ Date_____

CONSENT FOR PHOTOGRAPHS

I, _____, authorize UHA- WVU Eye Institute to photograph, videotape, or write and publish stories about me or my child _____, and to use these stories, photographs or video in publicizing the work and activities of UHA-WVU Eye Institute and its Children's Vision Rehabilitation Project Summer Institute.

I also authorize the release of information about my child's medical care for publication or broadcast.

I understand that I am not being paid for the use of my child's image.

I hereby release and hold harmless UHA- WVU Eye Institute, its parent and affiliated entities, staff, and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of my image.

This authorization shall expire three years from the date below. I understand that I have the right to stop photography, videotaping, or an interview, at any time, and to revoke this authorization at any time.

To revoke an authorization, communicate in writing to Privacy Officer, Health Information Management, PO Box 8049, Morgantown, West Virginia 26505. Revocation does not affect disclosures made while the authorization was in effect.

I understand that WVU Eye Institute will not condition my treatment, payment, enrollment or eligibility for health care services on either this authorization or revocation of the same.

Date:_____

Signature:_____

Address:_____

City, State, Zip Code:_____

Telephone:_____

Witness:_____