Children's Vision Rehabilitation Program

Bringing comprehensive rehabilitation services to West Virginia children with low vision

March 25, 2021

Dear Parents,

We are super excited to announce that plans for our **2021 Annual Summer Institute Day Camp** are underway! We are looking forward to having your kids attend camp with us. Last year, due to COVID-19, was the first time we couldn't hold our camp since we started in 2003 and we sure missed it. The camp is scheduled to be held June 7-10, 2021. The location is to be determined but will be either Bridgeport or Morgantown, WV. If you live more than 50 miles from our camp location we will be offering a stipend to assist with travel and hotel costs if you wish to stay in the area.

As usual, fun activities are being planned to enhance skills in the areas of cooking, orientation and mobility, self-help, crafts, and recreation. Recommended CDC guidelines pertaining to COVID-19 will be followed.

To apply, please complete the registration electronically using the following link or scanning the QR Code with your phone:

https://forms.office.com/r/Fktr41j4FP

SCAN to REGISTER

While registering electronically is preferred and the easiest way to apply, attached is the application if you wish to print, complete and return by mail. If you have any questions, please don't hesitate to contact us. We look forward to seeing your child at camp!

Sincerely,

It's simple! Just grab your phone, open your camera, point your camera at the code, open the link that pops up and register!

Becky Coakley
304-598-6970

Paula Lang
304-598-6965

West Virginia University Eye Institute · 1 Medical Center Dr. · P.O. Box 9193, Morgantown, WV 26506-9193
Rebecca Coakley, MA, CLVT Phone (304) 598-6970 Fax (304) 598-6928 Email: coakleyr@wvumedicine.org
Paula Lang, MA, CLVT Phone (304) 598-6965 Fax (304) 598-6928 Email: langp@wvumedicine.org

SUMMER INSTITUTE APPLICATION

Day Camp: June 7 - 10, 2021

To register electronically, just scan the QR code with your phone's camera and follow the link!

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

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: _____

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

Please register by May 10, 2021. Mail to:

Paula Lang, WVU Eye Institute, PO Box 9193, Morgantown, WV 26501, fax 304-598-6928, 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:_____