



Blind Service Association
17 N State St. Suite 1050
Chicago, IL 60602
312-236-0808

Thank you for your interest in Blind Service Association's six-week summer program, Pathways. Eligible students for Pathways are blind or low vision youth, from ages 10 through end of high school. The program runs 9:00 a.m. to 2:00 p.m., Monday through Friday from June 27 to August 5. For students in Chicago, transportation to and from Pathways is available each day. (Please inquire about transportation for suburban students.) Lunch and snacks are provided for all students. Activities include daily living skills, mobility and cane training, cooking, adaptive sports, cultural and recreational pursuits, and more. This summer, we are offering activities that offer a more extreme element to the program, such as Indoor Skydiving, Archery, Kayaking/Canoeing, and more. All precautions will be taken to ensure the safety of your student. If you would not want your student to participate in these particular activities, you will have the option to opt out. Because of the wide range of accommodations and contingencies, parents/guardians must complete and sign the attached forms, including forms for a VI teacher and physician. Send completed applications to Dustin Cather at Blind Service Association. Complete applications, including fee, will be reviewed. After review, students will be notified if they are approved to attend Pathways.

For more information contact
Dustin Cather
312-236-0808
dcather@blindserviceassociation.org

2022 PATHWAYS APPLICATION CHECKLIST

1. _____ 2022 Application and Information Form
2. _____ Signed Waiver of Liability
3. _____ VI Teacher Form
4. _____ Physician Form
5. _____ Application Fee (\$70). Includes daily lunch and transportation.

BLIND SERVICE ASSOCIATION'S PATHWAYS PROGRAM
2022 Application and Information Form
To be completed by parent or guardian

CHILD'S INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

School Name _____

Current Grade _____ Identified Gender _____

Age _____ Birthdate _____

PARENT/GUARDIAN INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Phone numbers: Home _____ Work _____ Cell _____

Parent/Guardian Email _____

Emergency contact (MUST BE INCLUDED):

Name of contact _____

Relationship to child _____

Phone numbers _____

For the benefit of your child and to maximize their opportunities at Pathways, please provide clear and thorough answers to the following questions.

What is your child's visual acuity?

Right eye_____

Left eye_____

Has your child undergone any operations or sustained serious injuries?

Yes _____ No _____ if yes, please explain.

Does your child use any of the following?

Wheelchair_____ Walker_____ Support Cane_____ Hearing Aid_____

Can your child carry five pounds of groceries for one city block?

Yes _____ No _____

Withstand sun exposure for one-half hour?

Yes _____ No _____

Other than vision loss, does your child have any physical or cognitive limitations?

How would you describe your child's level of activity?

Constantly on the go _____

Likes a lot of physical activity _____

Moderately active, likes some physical activity _____

Prefers slower paced indoor activities _____

Doesn't like to be active at all _____

Does your child have any behavioral condition that may impede him/her or other students from participating in any activities?

Does your child have any dietary restrictions, including vegetarian, vegan, lactose intolerance, gluten intolerance?

Yes _____ No _____ if yes, please explain.

Does your child have any allergies?

Yes _____ No _____ if yes, please explain.

Is your child currently taking any medications?

Yes _____ No _____ if yes, please explain.

Check the activities that your child likes to do:

Cooking _____

Shopping _____

Bowling _____

Skating _____

Swimming _____

Arts and crafts _____

Singing or performing _____

Other sports _____

Check the skills below in which your child needs improvement:

House cleaning _____

Grocery shopping _____

Cooking _____

Budgeting _____

Organizational skills _____

Leadership & self confidence _____

Orientation and mobility _____

Other, please explain.

Waiver of Liability for Pathways

The following must be completed and signed before the student is allowed to attend Pathways:

I hereby unconditionally release and indemnify Blind Service Association ("BSA"), and any of their officers, directors, executives, employees, agents, volunteers, and anyone working under, through or in connection with BSA with respect to any incident, claim, occurrence, loss, injury, or damage that could or may arise out of or in connection with such participation, including (by way of illustration and not limitation): travel to, from, and within any destination or location; use of any and all facilities used in connection with Pathways or any part thereof; social; cultural and other events (including, by way of illustration and not limitation) trips and educational programs; and any other events or activities in which my child may participate or engage, whether or not the same may be deemed to be related to Pathways or BSA.

I hereby grant permission for the administration of medical treatment and /or first aid to my child by any BSA volunteer and /or staff person and by those transporting my child, as their judgment deems advisable. I grant permission for these same individuals to make any necessary referrals to qualified physicians for the treatment of illness or accidents of a more serious nature. I understand that BSA will attempt to promptly notify me in the event of any serious illness or accident and prior to major surgery, except when a delay in such communication would endanger life in BSA's sole discretion. I hereby give permission to the physician selected by any BSA volunteer and /or staff person to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery, if deemed necessary for my child. In the event of serious illness or injury, I authorize emergency medical care for my child. I wish my child to be taken to the nearest Emergency Medical Facility, and the doctor listed below to be notified.

I hereby acknowledge that I am executing this instrument with full knowledge of the purpose and effect of the contents hereof, that I have had the benefit of legal advice and counsel of my own choosing, and that I execute the same freely and voluntarily, and on the basis that this instrument cannot be altered or revoked except in writing approved and signed by me. By signing below, I agree to the terms outlined above.

Doctor's Name _____

Doctor's Phone Number _____

Doctor's Practice Address _____

Signature of Parent/Guardian

_____ **Date** _____

Name of Parent of Guardian _____

Name of Child _____

PHOTO RELEASE

I give Blind Service Association permission to take my child's photograph for use to promote programs of Blind Service Association and general interest for the common good of the blind and visually impaired community.

Parent/Guardian Signature

Release of Information

I, _____, give permission to the
(Parent/ Guardian's Name)

Resource teacher of _____
(Child's Name)

to release all information requested on the attached teacher's form to Blind Service Association. I understand that the information given will only be used to determine my child's eligibility to participate in the Pathways Summer Program.

Parent/Guardian Name (please print)

Parent/Guardian Signature

Date

Early registration fee (before May 21st) is \$60 for each application. Regular registration fee is \$70 per application. All checks can be made out to Blind Service Association. All payments should be made as a check or money order.

For your child to qualify for free curb-to-curb transportation, applications are due on June, 10th. Otherwise, the deadline for registration is June 18th.

BLIND SERVICE ASSOCIATION'S PATHWAYS PROGRAM

2022 Teacher Form

--to be completed by VI Teacher—

Name of Student _____

VI Teacher's Name _____

VI Teacher's Email Address _____

Student's School _____

Address _____

City _____ St. _____ Zip _____

Phone _____

Current grade level of student _____

What is the student's visual acuity?

Left Eye _____

Right Eye _____

Does the student require a one-on-one aide at any time? _____

Has the student ever displayed behavioral problems with you, other adults, or peers? _____

Has the student ever displayed disruptive social emotional behavior? _____

Can this student travel independently inside buildings? Yes ___ No ___

Travel with a cane? Yes ___ No ___ (If not, why?)

Please check the following:

(A) Excellent, (B) Good, (C) Fair, (D) Poor, (E) Unknown

Enjoys playing with other children:

A _____ B _____ C _____ D _____ E _____

Likes team projects:

A _____ B _____ C _____ D _____ E _____

Likes team sports:

A _____ B _____ C _____ D _____ E _____

Overall grades:

A _____ B _____ C _____ D _____ E _____

Takes initiative before being told what to do:

A _____ B _____ C _____ D _____ E _____

Attitude toward supervision:

A _____ B _____ C _____ D _____ E _____

Does the student easily follow instructions?

A _____ B _____ C _____ D _____ E _____

Attitude when given instructions:

A _____ B _____ C _____ D _____ E _____

Completes tasks in a reasonable amount of time:

A _____ B _____ C _____ D _____ E _____

Rank the student's competency in the following areas (1=low – 5=high) or Do not know.

Budgeting	1	2	3	4	5	Do not Know
Task planning	1	2	3	4	5	Do not Know
Task completion	1	2	3	4	5	Do not Know
Mobility	1	2	3	4	5	Do not Know
House cleaning	1	2	3	4	5	Do not Know
Hygiene	1	2	3	4	5	Do not Know
Team sports	1	2	3	4	5	Do not Know
Physical exercise	1	2	3	4	5	Do not Know
Overall maturity	1	2	3	4	5	Do not Know

Signature of VI Teacher

BLIND SERVICE ASSOCIATION'S PATHWAYS PROGRAM
2022 Physician Confirmation Form
--to be completed by a physician—

Note: This form can be completed without a visit to the doctor, but check with your doctor if a visit is necessary.

Please have your physician fill out this form to confirm the status of your child's health & general physical condition. Thank you!

Name of Student _____

General Health:

Excellent _____ Good _____ Fair _____ Unsatisfactory _____

Physical limitations? Yes _____ No _____

If yes, please explain:

Are there any underlying medical conditions that make this applicant at higher risk for complications related to COVID-19? Yes _____ No _____

If yes, please provide written documentation for accommodations or additional precautionary measures this applicant may need:

Physicians Name: _____

Signature: _____

Date: _____

Phone Number: _____