

ARKANSAS DIVISION OF SERVICES FOR THE BLIND &
ARKANSAS SCHOOL FOR THE BLIND AND VISUALLY IMPAIRED
JUMP START APPLICATION

JUMP START APPLICATIONS ARE **DUE MARCH 31, 2015**

STUDENT'S NAME: _____

DATE OF BIRTH: _____ AGE: _____

SSN: _____ T-SHIRT SIZE: _____

SEX: _____ ETHNICITY: _____

MAILING ADDRESS: _____

CITY: _____ ZIP: _____

COUNTY: _____

HOME PHONE: _____ STUDENT'S CELL: _____

STUDENT E-MAIL ADDRESS: _____

HIGH SCHOOL ATTENDING: _____

GRADE LEVEL: _____

GRADUATION DATE: _____

NAME OF VISION TEACHER: _____

DSB COUNSELOR (IF APPLICABLE): _____

PARENTS' CELL PHONE: _____

PARENTS' E-MAIL ADDRESS: _____

VISUAL IMPAIRMENT: IN ORDER TO QUALIFY FOR THE JUMP START PROGRAM, THE STUDENT MUST MEET DIVISION OF SERVICES FOR THE BLIND ELIGIBILITY REQUIREMENTS. IF ELIGIBILITY HAS NOT ALREADY BEEN ESTABLISHED, THIS MUST TAKE PLACE PRIOR TO ACCEPTANCE INTO THE PROGRAM.

DIAGNOSIS: _____

HOW LONG HAVE YOU BEEN VISUALLY IMPAIRED: _____

VISUAL ACUITIES: RIGHT EYE: _____ **LEFT EYE:** _____

IN YOUR OWN WORDS, DESCRIBE YOUR VISUAL IMPAIRMENT AND THE LIMITATIONS CAUSED AS A RESULT:

WHAT MEDIA FORMAT DO YOU PREFER?

LARGE PRINT: _____ **SPECIFY FONT SIZE:** _____

BRAILLE: _____

WHAT ADAPTIVE EQUIPMENT AND AIDS ARE USED TO ENABLE YOU TO FUNCTION MORE INDEPENDENTLY IN THE CLASSROOM AND AT HOME: (CHECK ALL THAT APPLY)

- _____ **CCTV** _____ **PORTABLE HAND-HELD MAGNIFIER**
_____ **STAND OR HAND-HELD MAGNIFIER** _____ **MONOCULAR**
_____ **BRAILLER** _____ **SLATE AND STYLUS**
_____ **WHITE CANE**
_____ **NOTETAKER**
_____ **ADAPTIVE COMPUTER SOFTWARE**

OTHER (PLEASE SPECIFY):

GENERAL PHYSICAL FUNCTIONING:

A TYPICAL DAY OF JUMP START BEGINS AT 6:00 A.M. AND ENDS AT 10:00 P.M. STUDENTS WILL BE REQUIRED TO PARTICIPATE IN ALL ACTIVITIES THAT INCLUDE BUT ARE NOT LIMITED TO:

- **EXPOSURE TO SUN AND VERY HOT TEMPERATURES**
- **MANIPULATION OF A LARGE CAMPUS THAT CONSISTS OF HILLS AND UNEVEN SURFACES.**

PLEASE INDICATE ANY DISABILITIES OTHER THAN VISION, AND DESCRIBE SYMPTOMS, LIMITATIONS, AND MEDICATIONS THAT ARE TAKEN.

ORTHOTIC DEVICES USED: _____

IS THE STUDENT DEAF OR SEVERELY HEARING IMPAIRED? _____

PLEASE DESCRIBE THE STUDENT'S HEARING IMPAIRMENT AND ANY ACCOMMODATIONS NEEDED:

MENTAL AND COGNITIVE FUNCTIONING: STUDENTS WILL BE EXPOSED TO LARGE GROUPS OF PEOPLE AND NOISY ENVIRONMENTS.

PLEASE DESCRIBE ANY LIMITATIONS OR ISSUES RELATING TO MENTAL HEALTH TO INCLUDE BUT NOT LIMITED TO ANXIETY AND/OR SUICIDAL TENDENCIES:

YOU WILL BE REQUIRED TO SUBMIT A THOROUGH MEDICAL PROFILE THAT WILL BE REVIEWED BY THE ASBVI SCHOOL NURSE PRIOR TO THE BEGINNING OF JUMP START. THE NURSE HAS THE AUTHORITY TO OVERTURN ACCEPTANCE INTO THE PROGRAM IF THERE IS ANY DOUBT THAT THE STUDENT'S PHYSICAL WELL-

BEING WILL BE COMPROMISED AS A RESULT OF THE RIGOROUS DAILY SCHEDULE.

ACADEMIC INFORMATION: PLEASE RATE THE STUDENT'S PERFORMANCE IN THE FOLLOWING AREAS ON A SCALE OF EXCELLENT, GOOD, FAIR OR POOR.

_____ **READING**

_____ **HISTORY**

_____ **MATH**

_____ **SCIENCES**

_____ **ENGLISH**

_____ **BRAILLE**

_____ **COMPUTER**

_____ **KEYBOARDING**

IDENTIFY AREAS WHERE ENRICHMENT IS NEEDED, EXAMPLE: BRAILLE, ORIENTATION & MOBILITY OR ASSISTIVE TECHNOLOGY TRAINING:

ACTIVITIES OF DAILY LIVING: IN ORDER TO BE ELIGIBLE FOR THE JUMP START PROGRAM, THE STUDENT MUST BE ABLE TO INDEPENDENTLY BATHE, DRESS AND EXERCISE GOOD PERSONAL HYGIENE.

MARK YES OR NO TO THE FOLLOWING:

_____ **PREPARES SIMPLE MEALS AND/OR SNACKS**

_____ **HOUSEHOLD BUDGET EXPERIENCE**

_____ **MANAGES ALLOWANCE**

_____ **SHOPPING TO INCLUDE GROCERY AND HOUSEHOLD ITEMS**

_____ **INDEPENDENTLY DRESSES**

_____ **INDEPENDENTLY BATHES**

_____ **INDEPENDENT TOILETING SKILLS**

WHAT HOUSEHOLD RESPONSIBILITIES DOES THE STUDENT COMPLETE AT HOME AND WHAT ADDITIONAL TRAINING IS REQUESTED?

LIST ANY EXTRACURRICULAR ACTIVITIES IN WHICH THE STUDENT IS INVOLVED:

LIST THE STUDENT'S INTERESTS, HOBBIES AND LEISURE ACTIVITIES:

ORIENTATION AND MOBILITY

HAS THE STUDENT HAD ORIENTATION AND MOBILITY TRAINING?

YES _____ NO _____

IF YES, PROVIDE THE INSTRUCTOR'S NAME AND CONTACT INFORMATION:

DOES THE STUDENT USE A: (CHECK ALL THAT APPLY)

**____ MANUAL OR ELECTRIC WHEELCHAIR ____ POWERED SCOOTER
____ PERSONAL ATTENDANT ____ WALKER ____ CRUTCHES
____ SERVICE ANIMAL ____ SUPPORT CANE ____ WHITE CANE**

DOES THE STUDENT POSSESS THE STAMINA TO TRAVEL 200 FEET WITHOUT ASSISTANCE? _____

DOES THE STUDENT POSSESS THE STAMINA TO TRAVEL ¼ MILE WITHOUT ASSISTANCE? _____

IS THE STUDENT ABLE TO ASK FOR, UNDERSTAND AND FOLLOW DIRECTIONS? _____

WILL EXTREMELY HOT TEMPERATURES AFFECT THE STUDENT'S ABILITY TO PARTICIPATE IN OUTDOOR ACTIVITIES? _____

PLEASE INDICATE ANY ORIENTATION AND MOBILITY SKILLS THAT YOU NEED TO RECEIVE:

EMPLOYMENT:

**HAS THE STUDENT EVER BEEN EMPLOYED?
PLEASE INCLUDE VOLUNTEER, SUMMER OR PART-TIME JOBS:**

YES: _____ NO _____

IF YES, PLEASE LIST EMPLOYER NAMES, DATES OF EMPLOYMENT AND TASKS.

WERE ANY ACCOMMODATIONS OR MODIFICATIONS NEEDED TO ENABLE THE STUDENT TO PERFORM ESSENTIAL JOB DUTIES?

YES _____ NO _____

IF YES, PLEASE SPECIFY:

WHAT ARE THE STUDENT'S EMPLOYMENT GOALS? WHAT KIND OF SUMMER JOBS WOULD THE STUDENT LIKE TO DO? PLEASE INCLUDE SEVERAL OPTIONS:

Parent/Student Jump Start Acknowledgement
Arkansas Division of Services for the Blind &
Arkansas School for the Blind and Visually Impaired

Student Name: _____

Your initials indicate that you have read, understand, and agree with the terms set forth in order to apply and participate in the Jump Start Program.

_____ **The dates for Jump Start 2015 are June 8 through June 26, 2015.**

_____ **The deadline for receipt of completed applications is March 31, 2015.**

_____ **The Jump Start review committee will not be responsible for late applications or applications that may be lost in the mail.**

_____ **The Jump Start review committee reserves the option to select applicants who meet the mission and goals of the Jump Start program.**

_____ **Parent and student must complete the entire application. The review committee reserves the right to deny any application that is incomplete.**

_____ **Students who cannot participate in the entire three-week program need not apply.**

_____ **I understand that my child will be required to participate in the entire program. If I anticipate that other summer activities will prevent my child from fulfilling this obligation, I will immediately withdraw my child's application.**

_____ **I authorize Division of Services for the Blind (DSB) to obtain and share information with my child's school regarding Jump Start involvement; to include progress reports and recommendations for future training that will enhance vocational opportunities for my child.**

_____ **I am stating that my child does not have any violent tendencies and has never deliberately injured anyone, including him or herself.**

_____ **I understand that Jump Start is not a therapeutic program and DSB and Arkansas School for the Blind and Visually Impaired (ASBVI) cannot accept participants who might endanger themselves or other people.**

_____ **I understand that I am required to provide my child's medical information prior to Jump Start, and acceptance into the Jump Start program can be overturned per the ASBVI nursing staff's recommendation.**

_____ **I understand that if my child is found in possession of drugs, alcohol, weapons or any other contraband, he/she will be expelled from Jump Start, and I will be called to pick up my child immediately.**

_____ **I understand that the ASBVI campus is a smoke-free facility and possession or consumption of tobacco products is prohibited.**

_____ **I understand that the ASBVI campus is closed from Friday afternoon through Sunday afternoon, and I will pick up my child by 1:00 P.M. each Friday and bring him/her back to the ASBVI campus by 6:00 P.M. each Sunday evening.**

_____ **I will notify DSB or ASBVI if someone other than me will be picking up my child.**

_____ **If financial assistance is required to transport my child to and from Jump Start, I will make arrangements with his/her DSB counselor prior to the beginning of the program start date.**

_____ **I understand that I can be expelled if I am unable to follow the policy and rules of conduct of the Jump Start program. Jump Start and ASBVI staff reserves the right to request my immediate dismissal for blatant violations of Jump Start policy and rules of conduct.**

_____ **I understand that my child is responsible for their money and personal possessions and anything of value should be left at home.**

Please initial only one:

_____ **I DO give consent for my child to appear in public announcements, news articles, or ads about Jump Start.**

_____ **I DO NOT give consent for my child to appear in public announcements, news articles, or ads about Jump Start.**

SUPPORTING DOCUMENTATION:

PLEASE SUBMIT THE FOLLOWING DOCUMENTS WITH YOUR JUMP START APPLICATION.

- **STUDENT ESSAY:** PLEASE ATTACH AN ESSAY STATING WHY YOU WANT TO PARTICIPATE IN JUMP START, WHAT YOU WANT TO DO, WHAT YOU WANT TO LEARN, ETC. PLEASE PRINT OR TYPE. BE SURE TO INCLUDE YOUR NAME AT THE TOP OF THE PAGE.
- **PARENT ESSAY:** PLEASE ATTACH AN ESSAY EXPLAINING WHY YOU WANT YOUR CHILD TO ATTEND JUMP START. EXAMPLES INCLUDE BUT ARE NOT LIMITED TO GAINING WORK EXPERIENCE, MOBILITY TRAINING, LEARNING HOW TO COOK, ETC. PLEASE PRINT OR TYPE YOUR RESPONSE AND INCLUDE YOUR CHILD'S NAME AT THE TOP OF THE PAGE.
- **TRANSITION PLAN:** PLEASE CONSULT WITH YOUR ADVOCATE OR VISION TEACHER AND OBTAIN A COPY OF THE TRANSITION PLAN WHICH IS INCLUDED IN YOUR IEP.
- **LETTER OF RECOMMENDATION:** PLEASE OBTAIN A WRITTEN RECOMMENDATION FROM A TEACHER, HIGH SCHOOL OR DSB COUNSELOR THAT STATES WHY YOU WOULD BE A GOOD CANDIDATE FOR THE JUMP START PROGRAM.
- **LIST OF MEDICATIONS:** PLEASE SUBMIT A LIST OF MEDICATIONS YOUR CHILD WILL BRING AND TAKE DURING JUMP START.

BY SIGNING THIS APPLICATION, I SIGNIFY THAT ALL INFORMATION ON THIS APPLICATION IS ACCURATE AND TRUTHFUL.

PARENT SIGNATURE: _____

DATE: _____

STUDENT SIGNATURE: _____

DATE: _____

PLEASE RETURN THIS APPLICATION AND ALL OTHER SUPPORTING DOCUMENTS TO:

**EBONY KELLY
DHS/DSB
P. O. BOX 3237 SLOT # 102
LITTLE ROCK AR 72203**

PLEASE DIRECT QUESTIONS AND CONCERNS TO EBONY KELLY AT (501) 682-0344 OR 1-800-960-9270