DELTA GAMMA CENTER FOR CHILDREN WITH VISUAL IMPAIRMENTS
1750 S. Big Bend Blvd. Richmond Heights, MO 63117
Phone (314) 776-1300 * Fax (314)776-7808 * E-Mail info@dgckids.org * www.dgckids.org

GENERAL ADMISSION FORM ALL SERVICES

CHILD'S INFORMATION

Child's Name ______________________________ **Date of Birth** ____________________

Address ____________________ Additional Address if applicable ____________________

City ______________ **County** ____________ **State** ________ **ZIP** ________

School District/School ____________________ **Race** ______________ **Gender** M F

Visual Diagnosis, if known ______________________ Does child have health insurance coverage? Yes No

Other Medical Concerns/Diagnosis ______________________________

FAMILY INFORMATION

	MOTHER	FATHER	Guardian, if applicable
Name			
E-Mail			
Phone	Home ____________ Cell ____________	Home ____________ Cell ____________	Home ____________ Cell ____________
Employer			
Occupation			

Siblings (Name & DOB:) ______________________________

Emergency Contact Information Name ______________________________

Relationship ____________________ Phone ____________________

Family Financial Information (required by our funders)

____ $0 - $9,999

____ $10,000 - $14,999

____ $15,000 - $19,999

____ $20,000 - $29,999

____ $30,000 - $49,999

____ $50,000 - $99,999

____ $100,000 and greater

I/we understand that medical information will be obtained to determine eligibility for services or, for school age children, an IEP that indicates he or she receives vision services.

______________________________ ____________________

PARENT / GUARDIAN / RESPONSIBLE PARTY **DATE**

Revised 9/1/2015

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I understand that agencies and/or providers need specific information in order to provide services. By signing this form, I am allowing the named agencies/providers to exchange specific information to effectively provide or coordinate services for my child.

I, ____ give my informed consent for information regarding
Parent/Legal Guardian Name

____ / ______________________________ to be either
Child's Legal Name / Date of Birth

mutually exchanged or shared between the agencies / individuals listed below:

Pediatrician Name / Phone #	Ophthalmologist Name / Phone #
Neurologist Name / Phone #	School & School District Name / Phone #
Case Worker Name / Phone #	Service Coordinator Name / Phone #
First Steps (MO) Name / Service Coordinator / Phone #	CFC (IL) Name / Service Coordinator / Phone #
Regional Center Name / Phone #	PLB / Phone #
Name / Phone #	Name / Phone #
Name / Phone #	Name / Phone #
Name / Phone #	Name / Phone #

Permission to use photos of my child and media:

I hereby authorize and give my full consent to Delta Gamma Center for Children with Visual Impairments to take photographs, videotapes, and/or film of my child while receiving Delta Gamma Center services. I further agree these photographs, videotapes, or films can be used for any social media, public displays, publications, marketing and advertising purposes, without limitations or reservations.

I also have the option to limit photo use to: ____

____

Initial: **Yes, consent granted**________ **No, I do not consent**_______

I give my permission to release my name and contact information to the Delta Gamma Center agency representative so that they can contact me with information about events and activities.

Check one: **Yes** _____ **No, I do not wish to share this information** _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, and it is not a requirement of service. I can inspect or request copies of the information to be disclosed.

I have a right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the Delta Gamma Center. Unless I indicate on this form that I wish to specific a different expiration date, this authorization will expire in one year. ___________________ **(expiration date)**
My signature below acknowledges that I have read, understand and authorize release of my child's records.

____ ____________________________________

Signature of Parent / Guardian **Date**