Marion's Preschool Language Camp

Summer 2024 Application

Applications are due by April 15, 2024

Purpose and Philosophy:
Marion's Way is an intensive summer language enrichment program for children who are deaf or hard of hearing incorporating a language-rich environment and instruction with a focus on developing listening and spoken language skills. Theme-based learning experiences incorporated into language, cognitive, and literacy activities for children will support social, emotional, and pre-academic development. Technology will optimize auditory access. Parent participation and training will support the carryover of these skills to home and family environments. Applications will be considered on a first come first serve basis based on eligibility requirements.

Eligible Students:

- Ages 3-5
- Deaf or hard-of-hearing
- English spoken language levels of 2 years-5 years
- Participation is **required** for a speech/language, learning, and hearing assessments at the Marion Downs Center (MDC). This will include 1-2 clinic visits
- Parents participate in all parent information sessions
- Referral from parent, teacher, early intervention provider, speech-language pathologist, or audiologist
- Release of Information from clinical and school audiologist also needed

Schedule and Location:

- The 2-week program meets from 9:30-12:00 on Monday-Thursday mornings from July 15th-July 25th with an extended afternoon option.
- There will be a Parent Information Session on Friday July 12 at 3:30pm. Other parent sessions will be on Zoom during the session (time to be arranged).
- Assessments are completed in June at the MDC (4280 Hale Parkway, Denver 80220)
- Marion's Way Summer Camp meets at the Anchor Center (2550 Roslyn Street, Denver 80238)

Tuition and Scholarships:

- Tuition is $400 and includes 2 weeks of preschool and 2+ parent information sessions
- There is a non-refundable registration fee of $50
- Participation will not be limited by family's financial resources
- Scholarships are available

Camp Director: Nanette Thompson, MS, CCC-SLP

Today's date: ________/________/________
month day year

GENERAL INFORMATION:

Child's name: ____

Birthdate: _______/_______/_______

Address: ______________________________________ City & Zip: _______________________________

Parent 1 Name: ________________________________ Parent 2 Name: _____________________________

Phone (cell): _________________________________ Phone (home): ______________________________

Preferred Email: ________________________________

With whom is the child currently living?

____Both parents ____ Parent 1 _____ Parent 2 _____Foster parents/guardians ____Other

Languages used at home: (Please check all that apply)

English_____ Sign Language _____
Spanish_____ Other (Specify)_____

HEARING INFORMATION:

Onset of hearing loss: Present at birth_____ Acquired after birth_____ Don't know_____

If acquired, at what age? _____ years, _____ weeks/months (circle one)

Age at which hearing loss was confirmed by an audiologist: _____ years, _____ weeks/months (circle one)
Age at which intervention first started: _____ years, _____ weeks/months (circle one)
Age at which amplification was first received: _____ years, _____ weeks/months (circle one)

Type of amplification currently used: None _____ Hearing aid(s)_____
FM system_____ Cochlear implant_____
Osseointegrated device (Baha, Pronto, etc.)_____

Make and model of device(s):____

If your child has a cochlear implant:
Date left ear implanted: _________ Activated:_________
Date right ear implanted: ________ Activated:_________

Facility where hearing is tested: ____

Audiologists name:____

****Please attach a copy of current audiogram and most recent audiology report****

CURRENT COMMUNICATION METHOD:
Check the sentence that best describes how the child's primary caregiver (if not the mother or father) communicates with the child MOST of the time.

_____ I speak to my child. I do not use sign language.

_____ I typically speak to my child. I occasionally use some sign language.

_____ I typically speak AND sign to my child. I try to sign most or all of the time when I talk.

_____ I typically sign to my child WITHOUT speaking.

CURRENT SCHOOL AND THERAPY IF APPLICABLE:
NOTE: Answer each of the questions in this section in relation to the academic year your child just completed.

Name of School:_______________________________ School District: _____________________________

Name of Classroom Teacher: _________________________________

Name of Deaf Educator: ____

Name of Speech Pathologist: ____

Phone Number: ________________________________ Email:____

Please complete the following table indicating how many hours/minutes per week that your child is in each type of educational setting:

Type of Intervention	Hours	Minutes
Class primarily for deaf/hard-of-hearing children		
Class for children with a variety of special needs		
Class primarily for hearing children		
Other, please describe: ____		

Check the sentence that best describes how the child's teacher communicates with your child MOST of the time.

_____ The teacher speaks to my child. She/He does not use sign language.

_____ The teacher speaks to my child. She/He occasionally uses a little bit of sign language.

_____ The teacher typically speaks AND signs to my child. She/He tries to sign most/all of the time when speaking.

_____ The teacher typically signs to my child WITHOUT speaking.

Does your child receive speech or auditory therapy outside of school? Yes _______ No _____
If YES, amount of time per week: _______ Therapist's name(s): ____

Phone Number: ___________________________ Email: ____

CHILD'S OTHER SPECIAL NEEDS/CONDITIONS: (Please check all that apply.)

______ No other disabilities
______ Brain injury
______ Cerebral palsy (CP)
______ Specific Learning disability (LD)
______ Developmental/Cognitive delay
______ Autism/PDD
______ Balance disorder
______ Other disability. Please explain: ________________________________
______ Vision problem/impairment
______ Seizures/Epilepsy
______ Emotional/Behavioral problem
______ Motor problem
______ Central processing disorder
______ Cleft lip/palate
______ Sensory/Motor integration problem

Is your child receiving any intervention services for additional special needs/conditions (other than hearing loss)?

Yes_____ No_____

If Yes, name and type of program: ________________________________

Contact Person ________________________________

Email Address: ____________________ Phone: ____________________

Are you able to bring your child to the Marion Downs Center to do a speech/language/hearing/learning assessment?
Yes _____ No _____

Will you be able to attend 2 parent information sessions during the program and participate in your child's intervention? Yes ______ No _____

What else would you like us to know about your child?

____

____

Some audiology and speech language services are included as part of Marion's Way Summer Language Enrichment Program. Evaluations and some services will be billed to your insurance. If these are not benefits covered by your insurance, financial aid is available.

Insurance Provider Company Name

____

Member
ID # ____________________ Policy Holder____________________

Who referred this child to Marion's Way Summer Language Enrichment Program?
Name: ________________________________

Phone number: ________________________________

How did you hear about Marion's Way? ________________________________

____

Please attach a copy of your child's most recent IEP documents, including testing results and audiogram.
** This information needs to be included with your application for it to be processed.
** Please complete release of information included in this packet.

AUTHORIZATION TO SECURE AND RELEASE STUDENT INFORMATION

Date: _____________
Student Name: ______________________________ **Date of Birth:** __________________________
Parent/Guardian Name: _______________________ **Phone:**________________________________
Street Address: ____
City: ____ **State:** ________ **Zip Code:** _______________

I, ________________________________, authorize release of information specified below to/from The Marion Downs Center to allow inspection of records; exchange of treatment information; ongoing communication; and information by telephone. Any and all pertinent information includes, examination, diagnosis, history, treatment, and prognosis along with any other information you feel might be helpful.

Specifically (check all that apply):

	Copy of Medical Records
	Evaluations and assessments, including cognitive assessments, psychological assessments, vision, hearing, or speech/language assessments, occupational or physical therapy assessments, social-emotional assessments, learning assessments, and any reports or recommendations pertaining thereto.
	Education records, including grades, test records, Individual Education Plans, assessments, discipline records, psychological records, attendance records, vocational assessments and data, social and emotional records, exclusion contracts and behavior management plans.
	Other records not specified above (please note):

INFORMATION TO BE OBTAINED FROM/OR RELEASED TO:

Name (Audiologist)	Phone	Address
Name (Speech Pathologist)	Phone	Address
Name (School)	Phone	Address
Name (Physician)	Phone	Address

REQUEST & AUTHORIZATION: I hereby request and authorize the Marion Downs Center to secure and release information from the person or entity name above on this form. I understand that this information will be pertinent information concerning the student. I certify that this request has been made voluntarily and that the information described above is accurate, to the best of my knowledge. I understand that I may revoke the authorization at any time, except to the extent that action has already been taken to comply with it.

Without my express written revocation, this consent will automatically expire under one or more of the following conditions:
Upon receiving all requested information; if revoked in writing by the student or guardian; one year from the date of signature; or under the following conditions: ____
** I have been given the opportunity to read or obtain a copy of the Notice of Privacy Practices **

Signature of Patient/Guardian ____ Date: _____________

Signature of Witness ____ Date: _____________

Please Return to: The Marion Downs Center, 4280 Hale Parkway, Denver, CO 80220
Tel: 303-322-1871 Fax: 303-399-3411