Marion's Way Safari Literacy Camp

Little Sound Explorers (Preschool)

Applications are due by June 1st, 2026

Purpose and Philosophy:
Marion's Way Safari Literacy Camps are a fun engaging opportunity for children to build listening, language, and early literacy skills through music, stories, movement, and imaginative jungle adventures. These small groups help children with hearing technology practice listening, communication, and early reading skills in a supportive peer environment.

Theme-based learning experiences incorporated into language, cognitive, and literacy activities for children will support social, and pre-academic development. Technology will optimize auditory access. Parent education 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:
- Preschool: Little Sound Explorers
- Deaf or hard-of-hearing
- English spoken language levels of 3+ years
- Participation is **required** for a pre-camp initial consultation session for a speech/language and/or early literacy assessment **AND** an audiological assessment at the Marion Downs Center to be fit with a digital remote microphone system to be used during the week. (MDC).
- Parents must participate in a parent workshop following each camp to learn critical carryover strategies and activities to keep their child thriving.

Schedule and Location:
- Little Sound Explorers: The 1-week program meets from 10:00 to 11:30 Monday-Friday from July 27th through the 31st
- Initial consultations are completed prior to the start of camp at the MDC (5570 DTC Pkwy Ste 200, Greenwood Village, 80111)

Tuition and Scholarships:
- Tuition is $300 and includes 7.5 hours of language and literacy immersion in a group therapy setting.
- There is a non-refundable registration fee of $25
- Participation will not be limited by family's financial resources.
- Please contact us for a scholarship request form.

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

GENERAL INFORMATION:

Child's Name			
Birthdate (Month, Date, Year)			
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: **Please attach a copy of current audiogram and most recent audiology report**

When was onset of Hearing Loss?	Present at birth		Acquired after birth		Don't know	

If acquired, at what age?	Years		Months		Weeks	
Age at which hearing loss was confirmed by an audiologist	Years		Months		Weeks	
Age at which intervention first started	Years		Months		Weeks	
Age at which amplification was first received	Years		Months		Weeks	

* Pick either months or weeks – whichever is applicable

Type of amplification currently used:

None		Hearing Aid(s)		Osseointegrated device (Baha, Ponto, etc)	
FM System		Cochlear Implant(s)			

Make and Model of Devices:	

If your child has a cochlear implant	Date left ear implanted		Date activated	
	Date right ear implanted		Date activated	

Facility where hearing is tested	
Audiologist's Name	

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.
	Other (specify)

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 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.
	Other (specify)

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		Vision problem/impairment
	Brain injury		Seizures/Epilepsy
	Cerebral palsy (CP)		Emotional/Behavioral problem
	Specific Learning disability (LD)		Motor problem
	Developmental/Cognitive delay		Central processing disorder
	Autism/PDD		Cleft lip/palate
	Balance disorder		Sensory/Motor integration problem
	Other disability (Please explain):		

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 an initial consultation and/or speech/language/hearing/learning assessment?	Yes		No	
Will you be able to attend a parent information session during and/or after the camp?	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			
Medicaid ID #		Policy Holder Name	
Who referred this child to Marion's Way Summer Language-Literacy Enrichment Program?			
Name		Phone Number:	
How did you hear about Marion's Way Programs?			

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

Today's 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, 5570 DTC Pkwy Ste 200 Greenwood Village, CO
Tel: 303-322-1871 Fax: 303-399-3411