



# Marion's Way Safari Literacy Camp

## Wild Readers Safari (K-1st Grade)

*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:**

- K-1<sup>st</sup> Graders: Wild Readers Safari
- 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:**

- Wild Readers Safari: The 1-week program meets from 1:30-3:00 Monday-Friday from July 27<sup>th</sup> through the 31<sup>st</sup>
- 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	<input type="checkbox"/>	Parent 1	<input type="checkbox"/>	Parent 2	<input type="checkbox"/>	Foster Parents/ Guardians	<input type="checkbox"/>	Other	<input type="checkbox"/>
--------------	--------------------------	----------	--------------------------	----------	--------------------------	---------------------------	--------------------------	-------	--------------------------

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

English	<input type="checkbox"/>	Sign Language	<input type="checkbox"/>
Spanish	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>

**HEARING INFORMATION: \*\*Please attach a copy of current audiogram and most recent audiology report\*\***

When was onset of Hearing Loss?	<input type="checkbox"/>	Present at birth	<input type="checkbox"/>	Acquired after birth	<input type="checkbox"/>	Don't know	<input type="checkbox"/>
---------------------------------	--------------------------	------------------	--------------------------	----------------------	--------------------------	------------	--------------------------

If acquired, at what age?	Years	<input type="text"/>	Months	<input type="text"/>	Weeks	<input type="text"/>
Age at which hearing loss was confirmed by an audiologist	Years	<input type="text"/>	Months	<input type="text"/>	Weeks	<input type="text"/>
Age at which intervention first started	Years	<input type="text"/>	Months	<input type="text"/>	Weeks	<input type="text"/>
Age at which amplification was first received	Years	<input type="text"/>	Months	<input type="text"/>	Weeks	<input type="text"/>

\* Pick either months or weeks – whichever is applicable

**Type of amplification currently used:**

None	<input type="checkbox"/>	Hearing Aid(s)	<input type="checkbox"/>	Osseointegrated device (Baha, Ponto, etc)	<input type="checkbox"/>
FM System	<input type="checkbox"/>	Cochlear Implant(s)	<input type="checkbox"/>		

Make and Model of Devices:	<input type="text"/>
----------------------------	----------------------



--	--

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.

<input type="checkbox"/>	I speak to my child. I do not use sign language.
<input type="checkbox"/>	I typically speak to my child. I occasionally use some sign language.
<input type="checkbox"/>	I typically speak AND sign to my child. I try to sign most or all of the time when I talk.
<input type="checkbox"/>	I typically sign to my child WITHOUT speaking.
<input type="checkbox"/>	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.**

<input type="checkbox"/>	The teacher speaks to my child. She/He does not use sign language.
<input type="checkbox"/>	The teacher speaks to my child. She/He occasionally uses a little bit of sign language.
<input type="checkbox"/>	The teacher typically speaks AND signs to my child. She/He tries to sign most/all of the time when speaking.
<input type="checkbox"/>	The teacher typically signs to my child WITHOUT speaking.
<input type="checkbox"/>	Other (specify)

<b>Does your child receive speech or auditory therapy outside of school?</b>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If YES, amount of time per week	<input type="text"/>	Therapist's Name(s)	<input type="text"/>	
Phone Number	<input type="text"/>	Email:	<input type="text"/>	

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

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

Is your child receiving any intervention services for additional special needs/conditions (other than hearing loss)?			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If Yes, name and type of program	<input type="text"/>					
Contact Person	<input type="text"/>					
Email Address	<input type="text"/>	Phone	<input type="text"/>			

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	<input type="checkbox"/>	No	<input type="checkbox"/>
Will you be able to attend a parent information session during and/or after the camp?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

**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):**

<input type="checkbox"/>	Copy of Medical Records
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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