P.O. Box 45857. Madison, WI 53744
Phone: (608) 772-3787 Fax: (866) 854-3291
barb@occupaws.org
www.occupaws.org

## APPLICATION for Children's Visual Companion Dog

Child's Name ______________________________

Parent's Name(s) ______________________________ Date __________

Address ______________________________

Mailing Address ______________________________

Phone (______) __________ (______) __________ (______) __________
Home Cell Work

Email ______________________________

**On behalf of the above named child, I/We hereby apply to OccuPaws for a Children's Visual Companion Dog and for special, in-home training in the use and care of said dog, with the understanding that I/we will not be required to pay or promise to pay any amount of money therefore. To assist OccuPaws in determining whether or not our family can care for and benefit from a Visual Companion Dog, I/we submit the following information:**

Child's Date of Birth __________ Age ______ Gender: ☐ Male ☐ Female

Number and ages of children in household ______________________________

Please describe your child's personality (i.e. daring, outgoing, shy) ______________________________

How does your child react to new situations and/or environments? ______________________________

What types of activities does your child enjoy or participate in?

Indoor: ______________________________

Outdoor: ______________________________

Please describe your house or apartment ______________________________

______________________________

Please describe your neighborhood (i.e. downtown, rural, suburban) ______

______

How long have you lived at your present address? ☐ <6 months ☐ 6-12 months ☐ 1-5 yrs. ☐ 5+ yrs.

Do you anticipate a move or lifestyle change within the next year? ☐ Yes ☐ No

If yes, please explain ______

______

Does the above named child routinely travel independently? ☐ Yes ☐ No

Do you consider the child a confident traveler? ☐ Yes ☐ No

Current method of travel ☐ cane ☐ sighted guide ☐ guide dog ☐ other

Please describe the areas you and your child frequent ______

______

What obstacles/challenges do you encounter in the areas you frequent? ______

______

Do you encounter stray or loose dogs, aggressive dogs (restrained or behind fences), small animals (squirrels, rabbits, etc)?

______

Why does your family desire a Children's Visual Companion Dog? ______

______

Do you now or have you ever had dogs as pets? ______

What are the ages, sizes, breeds and personalities of the other dogs you currently have? ______

______

Please list any other pets ______
i.e. cat, rabbit, bird, hamster, guinea pig, ferret, etc.

## EDUCATION and TRAINING

Please attach a copy of your child's IEP (Individual Education Plan) to this application.

What school does your child attend?________________________________________________

What school district is your child enrolled?____________________________________________

Please list any special orientation and mobility training your child has had______________________

_____________________________________________________________________________

_____________________________________________________________________________

What is the name of your child's Vision Teacher? _________________________________________

What community organizations or activities relating to blindness are you involved with, if any? __________

_____________________________________________________________________________

_____________________________________________________________________________

## PARENT(S) OCCUPATION

Are you employed? ☐ Yes ☐ No

Occupation ____________________________________________________________________

Employer _____________________________________________________________________
Name

_____________________________________________________________________________
Address City State Zip Code

Supervisors name ______________________________ Phone (____) ____________________

If not employed, what is your present means of support? ___________________________________

Income Level: 5,000 – 10,000 a year _____ 30,000 – 40,000 a year _____

10,000 – 20,000 a year _____ 40,000 – or above a year _____

20,000 – 30,000 a year _____

Can you support the cost of a companion dog's food and health care? ___________________________

_____________________________________________________________________________

________________________

_____________________________________________________________________________

## EMERGENCY CONTACT INFORMATION

**Please list the name, address and telephone numbers of two family members to contact in case of an emergency.**

Name________________________________________ Relationship to applicant__________________

Home Phone___________________ Cell phone__________________ Work Phone_________________

Address_______________________________________________________________________________

City__________________________________ State__________________ Zip Code_________________

Name_________________________________________ Relationship to applicant__________________

Home Phone___________________ Cell phone__________________ Work Phone_________________

Address_______________________________________________________________________________

City__________________________________ State__________________ Zip Code_________________

## GENERAL HEALTH OF CHILD

Height _______ Weight ____________

Is the child legally blind? ☐ Yes ☐ No In what year did the child become legally blind? ______________

What is the child's cause of blindness? ________________________________________________

Please describe the child's residual vision ________________________________________________

________________________________________________________________________________

Does the child have a hearing impairment? ☐ Yes ☐ No Does the child wear hearing aides? ☐ Yes ☐ No

Does the child have any physical limitations or special needs? ______________________________

________________________________________________________________________________

________________________________________________________________________________

Has the child ever had seizures? ☐ Yes ☐ No Date of last seizure ______________

Does the child have diabetes? ☐ Yes ☐ No **If so, please have child's physician complete the diabetic report.**

Is the child insulin dependent? ☐ Yes ☐ No

What diet does the child follow?________________________________________ ☐ Strict ☐ Casual

Please list the child's dietary needs ________________________________________________

________________________________________________________________________________

Please list any surgeries ________________________________________________________

________________________________________________________________________________

Has the child ever had a substance abuse problem? ☐ Yes ☐ No

If yes, please explain ____________________________________________________________

Comments: ______________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**Does your child suffer from any of the following? (check all that apply)**

- ☐ coordination
- ☐ balance problems
- ☐ spasticity
- ☐ limited mobility
- ☐ reduced stamina
- ☐ muscular weakness
- ☐ brittle bones
- ☐ paralysis
- ☐ chronic pain
- ☐ frequent headaches
- ☐ speech impairment
- ☐ memory loss
- ☐ depression
- ☐ heightened emotions
- ☐ heat/cold sensitivity
- ☐ skin sensitivity
- ☐ deafness
- ☐ hearing loss
- ☐ allergies (please list)______________________________________________

______________________________________________________________

- ☐ other______________________________________________________

______________________________________________________________

**Does your child use any of the following? (check all that apply)**

- ☐ Assistance Dog
- ☐ Sighted guide
- ☐ White cane
- ☐ Low vision aids
- ☐ Hearing aid
- ☐ Leg brace
- ☐ Wrist brace
- ☐ Prosthesis
- ☐ Crutch
- ☐ Support cane
- ☐ Walker
- ☐ Manual wheelchair
- ☐ Other ______________________________________________________

______________________________________________________________

**Comments:** _____________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

## PERSONAL and PROFESSIONAL REFERENCES

**Incomplete information will greatly delay the processing of your application**

Please list the names and contact information of three personal references.

**1)** ______________________________ ( ) ______ ( ) ______
Name (Relationship to applicant) Home Phone Work Phone

______________________________
Address

______________________________
City State Zip Code

______________________________
Email Address

**2)** ______________________________ ( ) ______ ( ) ______
Name (Relationship to applicant) Home Phone Work Phone

______________________________
Address

______________________________
City State Zip Code

______________________________
Email Address

**3)** ______________________________ ( ) ______ ( ) ______
Name (Relationship to applicant) Home Phone Work Phone

______________________________
Address

______________________________
City State Zip Code

______________________________
Email Address

Please list the name and contact information of child's **Orientation and Mobility Instructor**

______________________________ ( ) ______
Name Phone Number

______________________________
Address

______________________________
City State Zip Code

______________________________
Email Address

Please list the name and contact information of your child's **Vision Teacher:**

______________________________ ( ) ______
Name Phone Number

______________________________
Address

______________________________
School District State Zip Code

**REASON FOR CHOOSING OCCUPAWS**?_______________________________________________

How did you learn about OccuPaws Guide Dog Association?

☐ OGDA Graduate_______________________________________________
Graduate's Name

☐ Lion's Club _______________________________________________
Name and Location of Club

☐ Convention or Conference _______________________________________________
Please List

☐ O & M Instructor _______________________________________________
Name of Instructor

☐ Other _______________________________________________
Please Explain

**Name of person who assisted in completing this form**

_______________________________________________ (      ) _______________
Name | Phone Number

_______________________________________________
Address | City | State | Zip Code

**I certify that the above information is true and correct.**

_______________________________________________ _______________
Parent's Signature | Date

_______________________________________________ _______________
Parent's Signature | Date

Please note: By signing and submitting this application your name will be added to the OGDA mailing list, please indicate to us if you DO NOT want to be added to this list; OGDA will not sell or share your mailing information with any third parties. All medical information contained in this document is confidential and will only be shared with those that you have given us authorization to share this information with as stated on the Information Release Form.

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# INFORMATION RELEASE FORM

I, ___________________________, hereby give my parental consent and authorization to release information about my child and myself from the physicians, agencies and schools listed in my application, for the purposes of determining eligibility for a Children's Visual Companion Dog for my family, to assist in providing appropriate medical attention, and for any other legal purpose deemed necessary by The OccuPaws Guide Dog Association.

_____________________________________________ _____________________

Parent Signature Date

_____________________________________________

Please print name

_____________________________________________

Child's Name

_____________________________________________

Child's Date of Birth

A copy of this form will be sent to each physician, agency, and school.

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# PHYSICIAN'S REPORT

**Applicant:** This form must be completed by your primary physician upon an examination.

**Physician:** Your patient has applied for a Children's Visual Companion Dog to enhance his/her mobility and independence. When completing this form, please keep in mind that the applicant, along with his/her family, will undergo rigorous training, both physical and mental. They will spend 14 to 21 days training and will be expected to walk a minimum of ½ hour twice daily in all types of terrain, with their companion dog, regardless of weather conditions. Your information will help us provide your patient with the training and instruction most suited to their needs. The Ophthalmologist's report and verification of blindness is a separate form. Thank you for your assistance.

Applicant's Name: ______________________________ Date of birth: __________
Address: ______________________________________________
Telephone: (_____) __________ Medical/Clinic ID number: ______________________

Height: ______ Weight: __________ Blood Pressure: __________ Pulse: __________ Respiration: ________

How long have you attended the applicant? First visit ____ ; # of years ____ Date of last tetanus immunization: ________

**Is applicant legally blind?** ☐ Yes ☐ No **Cause of blindness**: ______________________

**Does the applicant have any of the following medical problems?** (please answer yes or no)

| | | | |
|---|---|---|---|
| Arthritis ______ | Allergies ______ | Asthma ______ | Cancer ______ |
| Circulatory Problems ______ | Back Problems ______ | Amputations ______ | Addictions ______ |
| High Blood Pressure ______ | Seizures ______ | Heart Disorder ______ | Knee/Hip ______ |
| Psychiatric Problems ______ | Epilepsy ______ | Intestinal Problems ______ | Ulcers ______ |
| Headaches ______ | Foot Trouble ______ | Infectious Diseases ______ | Fainting ______ |
| Neuropathy ______ | Dexterity Problems ______ | Nervousness ______ | Speech Impairments ______ |

If yes, please explain ______________________________________________

______________________________________________

**Please list any surgeries** ______________________________________________

**Does the applicant have a hearing problem?** __________ **Which ear?** ☐ **Left** ☐ **Right** ☐ **Both**

Does applicant wear hearing aides? __________ Is hearing within normal range with aides? __________

**Does applicant have a learning disorder?** ______________________________

**Does applicant have any impairments of the use of either leg/foot?** __________ **Hand/arm** __________

**Does applicant have any limitations? Please explain** ______________________________

**Is applicant diabetic?** __________ **If yes please complete diabetic report.**

***Is applicant stable enough to undergo the rigors of training with a companion dog?** __________

**Date of exam on which report is based:** __________

______________________________
**Physician's Signature**

Doctor's name: ______________________________
*Please print*

Telephone: (_____) ______________________________

Hospital / Clinic Stamp

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# DIABETIC REPORT

**Physician and Applicant:** The OccuPaws Guide Dog Association does not have a nurse on staff. Applicant must be capable of administering his/her own injections and must be responsible for maintaining an appropriate lifestyle. Our protocol is to call 911, should the applicant need assistance.

Applicant's name: ______________________________

Is Applicant: ☐ Type I ☐ Type II ☐ Stable ☐ Brittle

Last Insulin reaction: ______________ please describe: ______________

______________________________

Are Insulin reactions frequent? ______________________________

Are Insulin reactions severe? ______________________________

What can be offered in the event of a reaction? ______________________________

Date of last hospitalization due to: Hypoglycemia __________ Hyperglycemia __________

Diet: ______________________________

Oral Medication: ______________ Daily Dosage ______________

Insulin Name: ______________ Daily Dosage ______________

Does Applicant utilize an Insulin pump? ☐ Yes ☐ No

If yes please list any special instructions ______________________________

Can Applicant self-administer Insulin? __________ Can Applicant adjust his/her own Insulin? __________

Please indicate any special instructions or suggestions ______________________________

______________________________

______________________________

**I understand the protocol of The OccuPaws Guide Dog Association and certify that the above information is true and correct.**

______________________________ Physician's Signature

______________________________ Applicant's Signature

______________________________ please print name

______________________________ please print name

______________ date

______________ date

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# MEDICATION AND HEALTH INSURANCE INFORMATION

**Physician and Applicant:** Please list all medications, strength, dosage, and reason for use. Also, please indicate any side effects that may affect the applicant during their time in training. Applicant is responsible for administering his/her own medication.

**Applicant's name** ________________________________________ **Date** ____________

| Medication | Strength | Dosage | Reason | Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Health Insurance Information**

Policy number: ______________________________________________

Policyholder's name: ______________________________________________

Insurance Company: ______________________________________________

Telephone number: ______________________________________________

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# OPHTHALMOLOGIST / OPTOMETRIST REPORT

**Applicant:** This form must be completed by your Ophthalmologist or Optometrist.

**Physician:** Your patient has applied for a Children's Visual Com[anion Dog to enhance his/her mobility and independence. Although our training sessions are conducted in the patients' home environment, we may travel to different locations within Southern Wisconsin. Your information will help us provide your patient with the training and instruction most suited to their needs. Thank you for your assistance.

Applicant's name: ______________________ Date: __________

Address: ______________________

City: ______________ State: __________ Zip Code: __________

Telephone: (____) __________ Date of Birth: ________ Height: ________ Weight: ________

**Details of Blindness:** Is Applicant legally blind? ☐ Yes ☐ No Date of last examination: ________

**Cause of vision loss:** **Primary** **Secondary**

OD ______________________ ______________________

OS ______________________ ______________________

Is Applicant's vision loss considered to be:

Progressive ________ Stable ________ Likely to improve ________ Uncertain ________

In what year did blindness occur? __________ How long have you attended this patient? __________

Visual Acuity

| | | | |
|---|---|---|---|
| With correction: | OD ________ | OS ________ | OU ________ |
| Uncorrected: | OD ________ | OS ________ | OU ________ |

Visual Fields

| | | | |
|---|---|---|---|
| Central: | OD ________ | OS ________ | OU ________ |
| Peripheral: | OD ________ | OS ________ | OU ________ |

Please describe residual vision:

| | No light perception | Some light perception | Gross movement | Count fingers | Read with lens |
|---|---|---|---|---|---|
| OD | ________ | ________ | ________ | ________ | ________ |
| OS | ________ | ________ | ________ | ________ | ________ |

Please list any ocular medications: ______________________

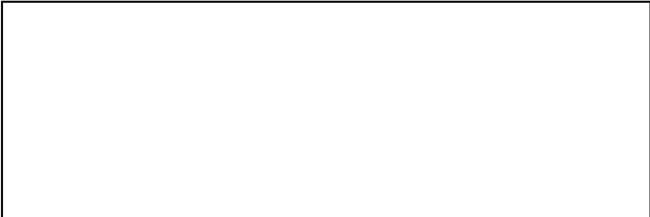
Comments: ______________________

**Date of exam on which report is based:** __________

______________________
**Physician's Signature**

Doctor's name: ______________________
*Please print*

Telephone: (____) ______________



Hospital / Clinic Stamp