

Number of children – Living with you: _____ Not living with you: _____

List children not living with you along with their address and phone number:

1. _____
2. _____
3. _____
4. _____

List any others on a separate sheet of paper.

List name, address and phone number of closest living relative:

Name	Address	Phone #
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In Case of emergency, please notify: _____
Name

Street Address

City	State	Zip	Phone
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Please list hobbies or activities you enjoy doing: _____

Have you had independent living skills training? _____. Where? _____

*Please include a recent photograph along with this application:

*Please attach written Doctor's verification of your status as being legally deaf and blind.

*Upon approval of this application you will be required to provide the following further medical and general information before final approval.

MEDICAL INFORMATION REPORT

Date of last physical examination: _____

*Please send copy of most recent report along with this information:

Do you smoke? _____ Do you drink alcoholic beverages? _____

DEGREE OF DEAFNESS AND OR VISION LOSS:

DEAFNESS: Total: _____ Partial: _____ Percent of loss: _____ Born deaf? _____

Cause of deafness: _____ At what age? _____

Do you have any speech at all? _____ Do you wear hearing aid(s)? _____

VISION LOSS: Total: _____ Light Perception: _____ Percent of loss: _____

Were you born blind? _____ Cause of blindness? _____

FAMILY AND PERSONAL HEALTH HISTORY:

Do any of your family members have a sight loss? _____

If yes, who? Father: _____ Mother: _____ Brother: _____ Sister: _____

Aunt: _____ Uncle: _____ Other: _____

Have you ever had eye surgery? _____ If yes; give date: _____

Type of surgery: _____

Other than vision and hearing, describe any mental or physical disabilities you may have: _____

Have you had other surgeries? _____ If yes, please list date and type of surgery: _____

Please list the name, dosage and for what condition you take regarding any prescription medication you are currently taking:

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

Your general health condition? _____

Excellent

Good

Fair

Poor

Have you or any of your immediate family members, (father, mother, brother, sister, husband, wife, or children), ever had any of the following problems?

Diabetes: ____ Who: _____
 Heart Disease: ____ Who: _____
 Kidney Disease: ____ Who: _____
 Allergic Disease: ____ Who: _____
 Cancer: ____ Who: _____
 Insanity: ____ Who: _____
 Suicide: ____ Who: _____
 Tuberculosis: ____ Who: _____
 Epilepsy: ____ Who: _____
 High Blood Pressure: ____ Who: _____
 Strokes: ____ Who: _____
 Blood Disease: ____ Who: _____
 Asthma: ____ Who: _____
 Migraines: ____ Who: _____

PAST HISTORY: Place check mark next to the name of each illness you have had.

Mumps:	Yes ___ No ___	Chronic Bronchitis:	Yes ___ No ___
Measles:	Yes ___ No ___	Frequent Bronchitis:	Yes ___ No ___
German Measles:	Yes ___ No ___	Glaucoma:	Yes ___ No ___
Chicken Pox:	Yes ___ No ___	Sinus Trouble:	Yes ___ No ___
Smallpox:	Yes ___ No ___	Thyroid Trouble:	Yes ___ No ___
Scarlet Fever:	Yes ___ No ___	Frequent Colds:	Yes ___ No ___
Whooping Cough:	Yes ___ No ___	Frequent Sore Throats:	Yes ___ No ___
Diphtheria:	Yes ___ No ___	Chronic Tonsil its:	Yes ___ No ___
Meningitis:	Yes ___ No ___	High Blood Pressure:	Yes ___ No ___
Polio:	Yes ___ No ___	Rheumatic Fever:	Yes ___ No ___
Typhoid Fever:	Yes ___ No ___	Heart Attack:	Yes ___ No ___
Jaundice:	Yes ___ No ___	Other Heart Trouble:	Yes ___ No ___
Liver Disease:	Yes ___ No ___	Syphilis:	Yes ___ No ___
Gall Bladder Trouble:	Yes ___ No ___	Gonorrhea:	Yes ___ No ___
Hemorrhoids:	Yes ___ No ___	Other Venereal Disease:	Yes ___ No ___
Ulcers:	Yes ___ No ___	Kidney Infection:	Yes ___ No ___
Colitis:	Yes ___ No ___	Other Kidney Trouble:	Yes ___ No ___
Hernia:	Yes ___ No ___	Bladder Infection:	Yes ___ No ___
Appendicitis:	Yes ___ No ___	Arthritis:	Yes ___ No ___
Pneumonia:	Yes ___ No ___	Bursitis:	Yes ___ No ___
Gout:	Yes ___ No ___	Bone Disease:	Yes ___ No ___
Valley Fever:	Yes ___ No ___	Neuritis:	Yes ___ No ___
Pleurisy:	Yes ___ No ___	Nervous Breakdown:	Yes ___ No ___
Hay Fever:	Yes ___ No ___	Other Diseases: _____	
Anemia:	Yes ___ No ___	_____	
Bleeding Tendency:	Yes ___ No ___	_____	

THIS INFORMATION WILL BE KEPT CONFIDENTIAL!