



APPLICATION FOR REQUESTING A GUIDE DOG

To be filled out by the applicant's family.

Please send only complete packages to **MIRA FOUNDATION USA, INC.**, 112 N. Poplar Street, Aberdeen, NC 28315. For additional information, please contact us by phone: 910.944.7757 or by email: info@mirausa.org

Student's First Name _____ Last Name _____

Birthdate _____ Gender _____

Address: Street _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email _____

Housing Arrangement: Single family house _____ Apartment _____ Condominium _____

Housing location: Urban _____ Suburban _____ Semi-rural _____ Rural _____

School Grade _____ Name of School _____

Height _____ Weight _____ Body type _____

Cause of blindness _____

Remaining level of sight _____

Does student have a hearing loss? _____ Does student wear a hearing aid? _____



APPLICATION FOR REQUESTING A GUIDE DOG, cont.

Does student have difficulty hearing when engaged in general activities? _____

What is student's general state of health? _____

Please specify any problems _____

Is student a diabetic? _____ Does student have any type of cardiac problems? _____

If so, please describe _____

How long has student been receiving Orientation & Mobility Training? _____

Please state the name of student's O&M Specialist _____

Is student currently receiving O&M Training? _____ If so, how often? _____

Please tell us why student wants a guide dog _____

Has student ever had a guide dog? _____ From which guide dog school was your dog obtained?

How did you learn about **MIRA FOUNDATION USA, INC.**? _____



I HEREBY AUTHORIZE **MIRA FOUNDATION USA**, INC. TO SEEK ANY OTHER NECESSARY INFORMATION IN ORDER TO COMPLETE MY FILE AND I UNDERSTAND THAT THIS INFORMATION WILL REMAIN CONFIDENTIAL.

SIGNATURE _____ DATE _____
(parent/guardian of children)

This Application Must be Submitted Along with the Following:

- 1.) Medical Report (1 page plus attachment, if necessary) completed and signed by general practitioner or pediatrician
- 2.) Letter from Ophthalmologist or Optometrist describing student's blindness (i.e. exact condition, general health, etc.)
- 3.) Letter of recommendation from Orientation and Mobility Specialist re: student's O & M skills
- 4.) VIDEO of student demonstrating O & M skills



**MEDICAL REPORT FOR APPLICATION FOR A GUIDE DOG FROM
MIRA FOUNDATION USA, INC.**

To be filled out by the family Physician.

Your patient is applying for a guide dog from our foundation. The program for obtaining a guide dog consists of 30 days of **rigorous training in all types of weather conditions**. We want to be certain that all guide dog recipients are physically able to participate in this program and request that you complete this report and also provide any other reports that you think might be relevant. Your patient will submit all medical reports to **MIRA FOUNDATION USA, INC.** along with the application and other necessary forms.

Name of Patient _____ Date of Birth _____

Address: Street _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Does your patient currently have or has your patient had any of the following conditions?

- | | | |
|--|--|---|
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Rheumatism or arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Orthopaedic problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nervous system disorders |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Circulatory problems |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Kidney/urinary problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Other physical problems |
| <input type="checkbox"/> Allergies (please describe) | <input type="checkbox"/> Digestive problems | (please describe) |
| <input type="checkbox"/> Pulmonary problems | <input type="checkbox"/> Cardiac problems | <input type="checkbox"/> Psychological Issues |

Please describe any of the above problems in as much detail as possible (use the back of this sheet if necessary). _____

What was the cause of the patient's blindness? _____

Does any sight remain? Yes ___ No ___ If yes, please provide details on back.

Please describe any special dietary restrictions _____

Please describe any medications prescribed on a daily basis and the dosage for each. _____

Physician's Signature

Date