

SCHOLARSHIP APPLICATION

The Robbie Foundation is proud to offer scholarships to individual children affected by developmental disabilities. Please read all questions and answer them completely. Please use a pen and clearly print or type your answers. Separate sheets may be attached if needed. Robbie Foundation Application Committee will consider only complete and legible applications.

APPLICANT INFORMATION:

| | | | |
|--|----------------------------|-------------------------------|---------------------------------|
| STUDENT'S FIRST NAME _____ | | STUDENT'S LAST NAME _____ | |
| DATE OF BIRTH: _____ / _____ / _____ (_____) | SSN: _____ - _____ - _____ | <input type="checkbox"/> MALE | <input type="checkbox"/> FEMALE |
| ADDRESS _____ | | | |
| CITY _____ | STATE _____ | ZIP _____ | |
| PHONE NUMBER _____ | EMAIL ADDRESS _____ | | |
| STUDENT'S DISABILITY _____ | SCHOOL ATTENDING _____ | | |

PARENT/GUARDIAN:

| | |
|----------------------|-----------------------|
| FIRST NAME (1) _____ | LAST NAME (1) _____ |
| FIRST NAME (2) _____ | LAST NAME (2) _____ |
| ADDRESS _____ | |
| CITY _____ | STATE _____ ZIP _____ |
| PHONE NUMBER _____ | EMAIL ADDRESS _____ |

PHYSICIAN OR HEALTH CARE PROFESSIONAL: (Please complete all that apply)

| | |
|--|----------------------------|
| PHYSICAL THERAPIST _____ | CONTACT INFORMATION _____ |
| OCCUPATIONAL THERAPIST _____ | CONTACT INFORMATION _____ |
| SPEECH THERAPIST _____ | CONTACT INFORMATION _____ |
| OTHER _____ | CONTACT INFORMATION _____ |
| PHYSICIAN'S NAME _____ | SIGNATURE (REQUIRED) _____ |
| CONTACT INFORMATION (ADDRESS AND TELEPHONE NUMBER) _____ | |



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EDUCATION:

Are you currently enrolled in an educational institution or program at this time? YES NO

If yes, where are you presently enrolled? _____

Present GPA: _____ Overall GPA: _____

Please list all school activities in which you have been involved: _____

What is your planned major? _____

To what school(s), college(s), universities, or programs are you applying? _____

Have you been accepted to any of the above? YES NO

If yes, which ones? _____

WORK EXPERIENCE:

Are you employed at this time? YES NO

If yes, where? _____

How many hours per week do you work? _____

List all the positions you have held (both paid and volunteer) during the past 5 years:

| | |
|----------------|--------------------------------|
| POSITION _____ | BUSINESS OR ORGANIZATION _____ |
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ACTIVITIES AND AWARDS:

List all organizations, clubs, and extra curricular activities in which you have been active.

(Youth groups, sports, drama, etc.): _____

What are your hobbies or special interests? _____

List any volunteer or community service you have been involved with: _____

LETTERS OF RECOMMENDATION/DOCUMENTATION:

Please submit three letters of recommendation. It is recommended that one letter come from your school counselor or instructor. The second letter can be from from a non-school, non-family individual who knows you through work or other activities. The third letter must come from a therapist or health professional documenting a developmental disability or special need.

On a separate sheet of paper, please explain the following:

1. Your reason for applying for a scholarship.
2. Your goals and plans for the future.
3. Any other information about yourself, including your family background and educational achievements, that will help the committee become better informed about you.

AFFIRMATION:

I have read the instructions, and completed this application to the best of my knowledge. If circumstances occur to change any of the information reported by me in this application, I understand that I must report this to the Robbie Foundation Application Committee.

SIGNATURE

DATE



AUTHORIZATION

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL INFORMATION:

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL MEDICAL INFORMATION REGARDING:

STUDENT'S FIRST NAME _____

LAST NAME _____

DATE OF BIRTH: ____/____/____ (____)

SSN: ____ - ____ - _____

I _____ hereby authorize Robbie Foundation to
PARENT/GUARDIAN SIGNATURE

RELEASE to: or OBTAIN from:

NAME OF PERSON(S) OR ORGANIZATION(S) _____

ADDRESS _____

PHONE _____

NAME OF PERSON(S) OR ORGANIZATION(S) _____

ADDRESS _____

PHONE _____

NAME OF PERSON(S) OR ORGANIZATION(S) _____

ADDRESS _____

PHONE _____

NAME OF PERSON(S) OR ORGANIZATION(S) _____

ADDRESS _____

PHONE _____

Verbal and/or written medical information to be obtained **ONLY** from health/mental health treatment plan, diagnosis and therapy reports.

I approve I do not approve



AUTHORIZATION

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL INFORMATION:

For the person(s) providing consent:

- This consent has been made freely, voluntarily and without coercion.
- I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law.
- I understand that I have the right to review information and material released.
- I understand that I have the right to refuse to disclose the following specified information:

- This authorization is valid for a period of one (1) year from the date of signing, but I also understand that I have the right to revoke this authorization in writing at any time.
- Finally, I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be redisclosed by the person or entity that receives this information.

PARENT/GUARDIAN SIGNATURE

PRINTED NAME

DATE

ADDRESS



PHOTO RELEASE

PHOTO RELEASE FORM:

Robbie Foundation occasionally uses photographs of patrons and events in its publications and on its Web site. Please sign this release form to grant RF permission to use your and/or your child's photo.

I hereby grant permission to Robbie Foundation to use my photograph on its Web site or in other official printed publications without further consideration, and I acknowledge the Foundation's right to crop or treat the photograph at its discretion. I also acknowledge that the Foundation may choose not to use my photo at this time, but may do so at its own discretion at a later date.

I also understand that once my image is posted on Robbie Foundation's Web site, the image can be downloaded. Robbie Foundation reserves the right to discontinue use of photos without notice.

STUDENT'S FIRST NAME

STUDENT'S LAST NAME

PARENT/GUARDIAN'S FIRST NAME

PARENT/GUARDIAN'S LAST NAME

ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

EMAIL ADDRESS

SIGNATURE

DATE

For persons under the age of 18, the permission of a parent or guardian is required on this Photo Release Form.

I hereby grant permission to the Robbie Foundation to use the photograph of my child as outlined above.

NAME OF CHILD UNDER 18:

FIRST NAME (1)

LAST NAME (1)

Please identify by first name only!

Please do not identify by name

PARENT/GUARDIAN SIGNATURE

DATE