



CONFIDENTIAL

TYPE OR PRINT

COMPLETE BOTH PAGES

I. GENERAL INFORMATION <i>To be completed by Teacher/Guardian</i>		
Student's Name	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth
Name of Parent	Address of Parent <i>Street, City, County, State, Zip</i>	Telephone Area/No.
Signature of Parent* ➤		Date Signed <i>Mo./Day/Yr.</i>

***Consent:** Parent signature for Voluntary Release to county agency (if the child is B-3), local school district, Department of Public Instruction for purposes of educational programming and/or registry with the American Printing House for the Blind. This consent can be revoked at any time, cannot be redisclosed to others for any purpose, and is valid for three years from date signed.

Return completed form to (Name & Title)	Address or Fax	Return Date
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II. Background Information <i>To be completed by Teacher/Guardian</i>	
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Questions and Concerns by Teacher of Visually Impaired, Caregiver, or Service Provider

- This child is known to have a documented hearing loss
- This child is known to have an additional disability. *If so, describe.*

III. Ocular Information <i>To be completed by Eye Care Specialist/Physician</i>										
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Visual Acuity	Distant Vision			Near Vision <i>in M Sizes</i>			Prescription				Instruments Used	
	Without Correction	With Best Correction	Measured at what distance	Without Correction	With Best Correction	Measured at what distance	Sph.	Cyl.	Axis	Add		
Right Eye (O.D.)												<input type="checkbox"/> Preferential looking tests <input type="checkbox"/> VEP Visual Evoked Response <input type="checkbox"/> Lighthouse <input type="checkbox"/> Feinbloom <input type="checkbox"/> Snellen <input type="checkbox"/> Lea Symbols <input type="checkbox"/> HOTV <input type="checkbox"/> Tangent Screen <input type="checkbox"/> Other
Left Eye (O.S.)												
Both Eyes (O.U.)												

If unable to test, does the diagnosis suggest a visual acuity of 20/70 or less in the better eye after correction or a field restriction of 50° or less?

- Yes No

Field Loss Tested <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes <input type="checkbox"/> Central <input type="checkbox"/> Peripheral	Widest Diameter of Remaining Visual Field <i>In degrees</i> <input type="checkbox"/> O.D. <input type="checkbox"/> O.S.	Is Child Legally Blind from Field Restriction: 20° or less <input type="checkbox"/> Yes <input type="checkbox"/> No
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Does the Child Exhibit Deficits in:

- Color Vision Depth Perception Night Vision

IV. CAUSE OF BLINDNESS AND VISUAL IMPAIRMENT*To be completed by Eye Care Specialist/Physician*

Present ocular and/or cortical (cerebral) condition(s) responsible for vision impairment and Etiology.

Etiology:

Present Ocular Pathology

 O.D. O.S. O.U.

Cortical Visual Impairment

 Yes No**V. PROGNOSIS AND RECOMMENDATIONS***To be completed by Eye Care Specialist/Physician*

Student's Vision Impairment

 Stable Degenerative Potentially Degenerative Fluctuating Uncertain

Recommended Treatment

 Patching Drop Pressure Checks Low Vision Evaluation
 Other *Specify:*Glasses or Contacts *Check all that apply* Prescription Tinted Lenses/Sunglasses Safety Lenses Not Needed
 Worn constantly Worn for distance viewing Worn for close workPhysical Activities *Is there a medical reason for limiting participation in contact sports or physical education?* No
 Yes *If yes, explain.*

Student is At Risk For Retinal Detachment

 Yes NoOther Concerns *Specify:*

Were Low Vision Aids Recommended?

 No Yes *If Yes, List.***VII. SIGNATURES***To be completed by Eye Care Specialist/Physician*Name of Examiner *Please Print*Date of Examination *Mo./Day/Yr.*Recommended Date for Next Exam
Mo./Day/Yr.

Signature of Examiner

 M.D. Date Signed *Mo./Day/Yr.*
 O.D.Address *Street, City, State, Zip*Telephone *Area/No.*