Patient’s Name: D.O.B: Date of most recent examination:

**Attention: Eye Care Specialist**
**Please address each item below. Your thoughtfulness in completing this report is essential for determining the patient’s eligibility for receiving appropriate educational services**.

**Diagnosis:

Background Information** (history, date of onset, surgery, familial eye conditions, etc.):

**Etiology** (cause) **of vision loss:**

**Visual Acuity: Distance Vision Near Vision**

 Without Current Rx With Best
Correction Correction

 Without Best
 Correction Correction

OD (right) / / / @ cm OS (left) / / / @ cm
OU (both) / / / @ cm

**Complete this next section ONLY if the acuity cannot be measured. Please check the most appropriate estimation of visual acuity / performance below:**
\_\_\_\_\_\_\_ Child functions better than 20/70 corrected, in his or her best eye.

\_\_\_\_\_\_\_ Child functions between 20/70 and 20/200 corrected, in his or her best eye.

\_\_\_\_\_\_\_ Central visual acuity of 20/200 or less in the better eye with best correction or peripheral field is so contracted that the diameter of such field subtends an angular distance of no greater than 20 degrees (Meets the Definition of Blindness – MDB).

\_\_\_\_\_\_\_ Visual performance is reduced due to a brain injury or dysfunction and visual functioning meets the definition of blindness (MDB). Students in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment.

**Prognosis: \_\_\_\_\_\_** Permanent \_\_\_\_\_\_ Stable \_\_\_\_\_\_ Temporary \_\_\_\_\_\_Progressive/Unstable

Comments:

**Color Vision Function:** \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal Describe if abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Muscle Function:** \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal Describe if abnormal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Visual Field:** Does the student have a field loss? \_\_\_\_\_ No \_\_\_\_\_ Yes

 Describe if field loss is present:

 **For students with glaucoma or at risk of glaucoma:** Intraocular Pressure Reading R \_\_\_ \_ L \_\_\_\_\_

**Treatment Recommended:
\_\_\_\_** Prescription Glasses – to be worn: \_\_\_\_ full time \_\_\_\_ distance only \_\_\_\_ near only

**\_\_\_\_** Safety Glasses – to be worn: \_\_\_\_ full time other needs

\_\_\_\_ Patching (schedule): R \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ L \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Surgery (date recommended) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Low Vision Evaluation \_\_\_\_ Low Vision Aid (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Other \_\_\_\_ Refer for other medical treatment/exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School personnel, including a teacher trained in the education of children with visual impairment, will complete educational assessments to determine the child’s eligibility for special education services, a need for braille, large print, etc**. **Please note any other medical recommendations you may have for this child:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Eye Care Specialist Name (please print) Eye Care Specialist Signature ­­­ Date*

**Thank you for your time & thoroughness in providing this important information to**

**(Insert Name) School District.**