<u>**Confidential**</u>

Kentucky Instructional Materials Resource Center
1867 Frankfort Avenue, Louisville, KY 40206 (502) 897-1583

REGISTRATION AND EYE REPORT FOR CHILDREN WITH VISUAL PROBLEMS

<u>**Instructions (Please Print)**</u>**:** An eye examination is required for students to be registered. If the student has not been previously registered, the eye examination must have been within one year. This form is to be completed by the eye specialist (ophthalmologist or optometrist), the superintendent or director of special education, and the parent or guardian.

Name of Pupil: ____________________________________ **Sex:** _____ **Sch. District:** ______________________
(First) (Middle) (Last)

Address:____ **Date of Birth:** _______________________
(No. and Street) (City or town) (State) (Zip Code) (Month) (Day) (Year)

Grade: _____**School:** ____________________________ **Address:** ______________________________________

How Served (Circle One): IEP: VI/Only IEP: VI/Multiple 504 Plan Other

Primary Reading Medium (Circle One): Print Braille Auditory Prereader Nonreader

Secondary Reading Medium (Circle One): Print Braille Auditory Not Applicable

(Do not duplicate the primary and secondary reading media)

I. History

A. Probable age of onset of vision impairment: Right eye (O.D.) ________________ Left eye (O.S.) ________________

B. Severe ocular infections, injuries, operations, if any, with age at time of occurrence ____________________________
____

C. Has pupil's ocular condition occurred in any blood relative(s)? ______ If so, what relationship? _________________

II. Measurements*

A. Visual Acuity

	Distant Vision			Near Vision			Prescription Lenses		
	Without correction	With best correction	With low vision device	Without correction	With best correction	With low vision device	Sph.	Cyl.	Axis
Right (O.D.)									
Left (O.S.)									
Both (O.U.)							Date:		

* If it is not possible to obtain a visual acuity measure, what is your opinion of what this child sees?
a. NLP __ b. Light perception __ c. Hand motion __ d. Count fingers e. Worse than 20/200 __ f. 20/70-20/200 __

B. If low vision device is prescribed, specify type and recommendations for use. ____________________________

C. FIELD OF VISION: (indicate on back of page) Right eye (O.D.) _____________ Left eye (O.S.) ______________

D. Is there impaired color perception?_________ If so, what color(s)? ____________________________________

E. Does this student's corrected vision meet the legal definition of blindness? _____ Yes _____ No

III. Cause of Blindness or Vision Impairment

A. Present ocular condition(s) responsible for vision impairment. (If more than one, specify all but <u>underline</u> the one which probably first caused severe vision impairment.)
O.D. ____
O.S. ____

B. Etiology (underlying cause) of ocular condition. primarily responsible for vision impairment (e.g. specific disease, injury, poisoning, heredity or other prenatal influence).
O.D. ____
O.S. ____

IV. Prognosis and Medical Recommendation

A. Is vision considered to be (Circle One): Stable Deteriorating Capable of Improvement Uncertain

B. What medical treatment is recommended, if any? ____

C. Is reexamination advised? ________ If so, after what interval? ______________________________________

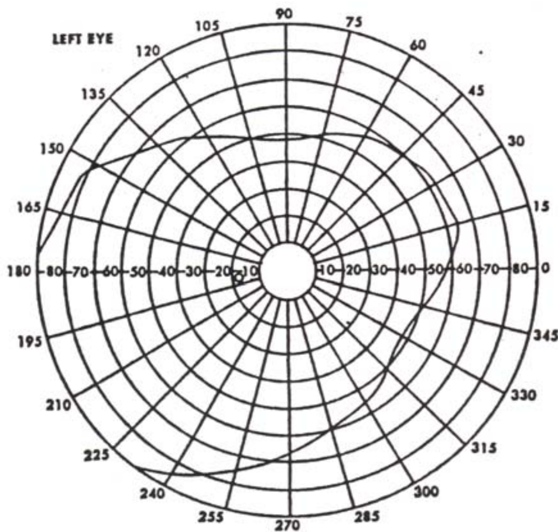
D. Glasses: Not needed _______ To be worn constantly ______ For close work only ______ Other (specify) ________

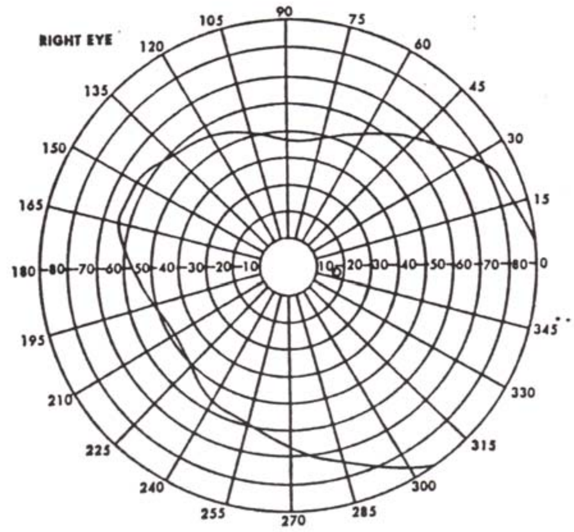
E. Lighting requirements: Average _____________ Better than average ___________ Less than average ____________

F. Physical activity: Unrestricted _______________ Restricted, as follows ___________________________________

Field Test Used: ____

Left Eye _________________________ **Right Eye** _________________________





Test Object: Color(s) _________________________
Size(s) _______________ **Distance(s)** __________

Test Object: (Color(s) _________________________
Size(s) _____________ **Distance(s)** ________________

Certificate and Authorization

____

PRINT or TYPE Name of Licensed Ophthalmologist or Optometrist

____

Signature of Licensed Ophthalmologist or Optometrist

____

Date of Examination

____

Address

____ ______________________________________

City **State** **Zip** **Telephone Number (including area code)**

I, hereby, certify that the above named pupil is enrolled in the ____

____School District.

____ ________________________________

Superintendent or Director of Special Education Signature Date

I hereby, authorize the release of the results and recommendations from this examination to school officials, state educational and health officials, and state rehabilitation officials for their use in any educational, rehabilitation, health statistical, or information dissemination purpose that may be desired. It is understood that all will be treated as confidential.

____ ________________________________

Parent/Guardian Signature **Date**

Revised 11/09