Kentucky Instructional Materials Resource Center

Registration and Eye Report Form for Children with Visual Impairments

Section 1: Demographics

Student Name: ______________________________________ **DOB:** __________________

School District and/or School: ___________________________ **Sex:** M ☐ F ☐ **Grade:** ________

How Served: IEP: VI/Only ☐ IEP: VI Multiple ☐ 504 Plan ☐ Other ☐

Primary Reading Medium: Print ☐ Braille ☐ Auditory ☐ Prereader ☐ Symbolic/Nonreader ☐

Secondary Reading Medium: Print ☐ Braille ☐ Auditory ☐ Not Applicable ☐

Section 2: Acuities and Visual Fields If unable to obtain Snellen Acuity, consider the FDB criteria

	Distance Acuity (ft.)			Near Acuity (in.)		
	O.D.	**O.S.**	**O.U.**	**O.D.**	**O.S.**	**O.U.**
Corrected:						
Without Correction						

Counts Fingers: ☐ O.D. ☐ O.S. **Hand Movement:** ☐ O.D. ☐ O.S.

Object Perception: ☐ O.D. ☐ O.S. **Light Perception:** ☐ O.D. ☐ O.S.

Is there a field limitation ☐ Yes ☐ No If yes, please describe: ______________________________

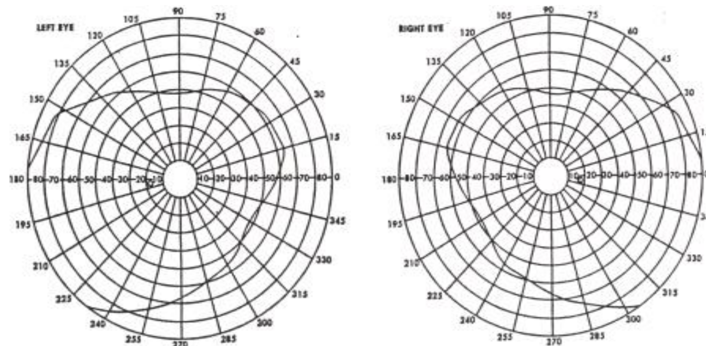
Is there impaired color perception? Yes ☐ No If yes, what color(s)? ________________________

Section 3: Visual Field

Field Test Used: ____

Left Eye ______________________________ Right Eye __________________________________

Figure 1: Field of Vision Chart



Test Object: Color(s) __________________________ Test Object: (Color(s) __________________________

Size(s) _____________ Distance(s) _____________ Size(s) _____________ Distance(s) _____________

Section 4: Prescription Complete if glasses and/or contact lenses prescription issued

OD: Sphere __________ Cylinder __________ Axis __________

OS: Sphere __________ Cylinder __________ Axis __________

Glasses: ☐ To be Worn Constantly ☐ For Close Work Only ☐ For Distance Only ☐ For Protection

Section 5: Visual Diagnosis & Prognosis

Diagnosis: ____

Prognosis: ☐ Stable ☐ Unstable ☐ Capable of Improving ☐ Uncertain

What treatment is recommended, if any? ____

Is re-examination advised? ☐ Yes ☐ No If yes, after what interval? ____________________________

Lighting requirements: ☐ Average ☐ Better than average ☐ Less than average

Physical activity: ☐ Unrestricted ☐ Restricted, as follows: ______________________________

Section 6: Cause of Blindness or Visual Impairment and History

A. Present ocular condition(s) responsible for vision impairment. OD ____________________
OS ____________________

B. Etiology (underlying cause) of ocular condition primarily Responsible for vision impairment (e.g. specific disease, Injury, poisoning or other prenatal influence). OD ____________________
OS ____________________

C. Probable age of onset of vision impairment: OD ____________ OS ____________

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

E. Has pupil's ocular condition occurred in any blood relative(s)? ☐ Yes ☐ No
If yes, what relationship? ____________________

Section 7: Certification of Visual Impairment/Blindness (Please mark all that apply)

☐ **Visually Impaired (VI)** 20/70 or less in better eye after correction or there is a limited visual field that could adversely affect educational progress.

☐ **Meets the Definition of Blindness (MDB)** 20/200 or less in the better eye after correction or visual field no greater than 20 degrees.

☐ **Meets the Definition of Blindness (MDB) Non-changing immutable condition** such as (bilateral enucleations, etc.)

☐ **Functions at the Definition of Blindness (FDB)** Students in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment.

Section 8: Doctor Authorization

Date of Eye Examination: ____________________

Name of Licensed Ophthalmologist or Optometrist: *Print* ____________________

____
Signature of Ophthalmologist or Optometrist

Name of Practice: ____________________

Address: ____________________

____

City **State** **Zip Code**

Telephone Number *(Including Area Code)* ____________________

Section 9: School District Certification and Parent Authorization

I hereby, certify that the above named pupil is enrolled in the ____________________ School District.

____________________ ____________________
Superintendent or Director of 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