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 Reader ☐

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: _____

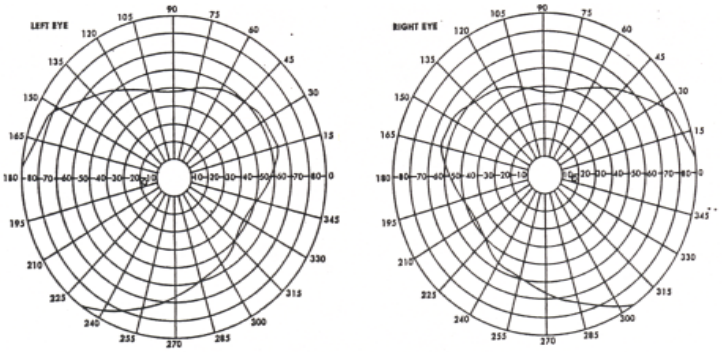
Is there impaired color perception? Yes ☐ No If yes, what color(s)? _____

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