Visual Impairment Program

Student Information

Student's Name: ______________________DOB: _____________Student ID#:_____________

Home Address: ____

Home Phone #: _________________Cell #:__________________Cell #: __________________

Parent:_____________________________email: ___________________________________

Parent:_____________________________email:____________________________________

School: ____Grade: ____________

School Address: ______________________________________School Phone:___________

Area of Eligibility in Visual Impairment Program: ☐ Blind ☐ Visually Impaired

IEP Duration: ______________________________Re-Evaluation Due Date: _________________

IEP Service Delivery Time: _________________________________

Ophthalmologist/Optometrist: _____________________________Exam Date: ______________

Visual Diagnosis: ____

Distance Visual Acuity: OD: 20/______ OS: 20/______ OU: 20/______

Near Visual Acuity: OD: 20/______ OS: 20/______ OU: 20/______

Prognosis: ☐ Stable ☐ Guarded ☐ Unstable Visual Fields: _______________

Glasses Prescription: ☐ yes ☐ no If yes, purpose: ______________________________

Team Members:

Name	Role	Email	phone

Alternative Instructional Materials (AIMs)

☐ None Needed ☐ Large Type ☐ Braille ☐ Auditory ☐ Electronic Text

Low Vision Devices: ____

Assistive Technology: ____

Classroom Testing Accommodations: ____

Support for School Personnel: ____