

PINELLAS COUNTY SCHOOLS
EXCEPTIONAL STUDENT EDUCATION
PROGRAM FOR STUDENTS WITH VISUAL IMPAIRMENTS – EYE REPORT FORM
For Official School Use Only

According to State of Florida Administrative Code Rule 6A-6.03014(1)(a-d), the definition of students who are visually impaired includes a student who is blind, has no vision, or has little potential for using vision; a student who has low vision; a student who has a visual impairment after best possible correction that adversely affects the student's educational performance and a student who has been diagnosed with a progressive condition that will most likely result in a visual impairment or no vision after best correction.

Name: _____ Sex: ☐ M ☐ F Date of Birth: _____

Address: _____

City: _____ Zip: _____ Phone: _____

Consent: I understand this information will be used for developing and implementing intervention plans for my child and family. This consent covers any phone calls between IFSP/IEP staff and the physician. My consent is given voluntarily and is valid for up to one year from the date below. I understand that I may withdraw this consent at any time.

Parent Signature: _____ Date: _____

Return completed form to: _____

OPHTHALMOLOGIST / OPTOMETRIST (please print)

Name of Examiner: _____

Phone: _____ Fax: _____

EYE EXAMINATION DATE: _____

I. Ocular History (e.g., previous eye diseases, injuries or operations). Age of onset: _____

History: _____

II. Diagnosis: Cause of visual loss, Check all that apply. Indicate OD, OS, OU.

- | | | | |
|--|---|---|--|
| ☐ Achromatopsia | ☐ Coloboma | ☐ Myopia | ☐ Retinoblastoma |
| ☐ Albinism | ☐ Cortical Visual Imp. | ☐ Nystagmus | ☐ Rod Cone Dystrophy |
| ☐ Amblyopia | ☐ Glaucoma | ☐ Optic Atrophy | ☐ ROP Stage ____, Zone ____ |
| ☐ Aniridia | ☐ Hemianopia | ☐ Optic Nerve Hypoplasia | ☐ Scotoma |
| ☐ Aphakia | ☐ Hyperopia | ☐ Ptosis | ☐ Strabismus |
| ☐ Astigmatism | ☐ Leber's | ☐ Retinal Detachment | ☐ Stargardts |
| ☐ Cataracts | ☐ Macular Degen. | ☐ Retinitis Pigmentosa | ☐ Other: _____ |

III. Prognosis: ☐ stable ☐ deteriorating ☐ capable of improvement ☐ guarded

IV. Measurements:

- a. Visual Acuity is required for determining eligibility. Please offer your best professional estimate of visual functioning/student's acuity. ***Please do not state student cannot be assessed.*** Complete this box using Snellen acuities/equivalents or NLP, LP, HM, CF, LB (legally blind).

BEST CORRECTED NEAR ACUITY:

BEST CORRECTED DISTANCE ACUITY:

R (OD)	R (OD)
L (OS)	L (OS)
B (OU)	B (OU)

b. Does the child's eye condition cause an impairment manifested by at least one of the following:

- ☐ A visual acuity of 20/70 or less in the better eye with correction.
- ☐ A peripheral field so constricted that it affects the student's ability to function in an educational setting.
- ☐ A diagnosis of visual impairment even with correction that may affect the student's ability to function in an educational setting.
- ☐ A progressive loss of vision that may affect the student's ability to function in an educational setting.
- ☐ None of the statements apply.

Is there impaired color vision? ☐ no ☐ yes, explain: _____

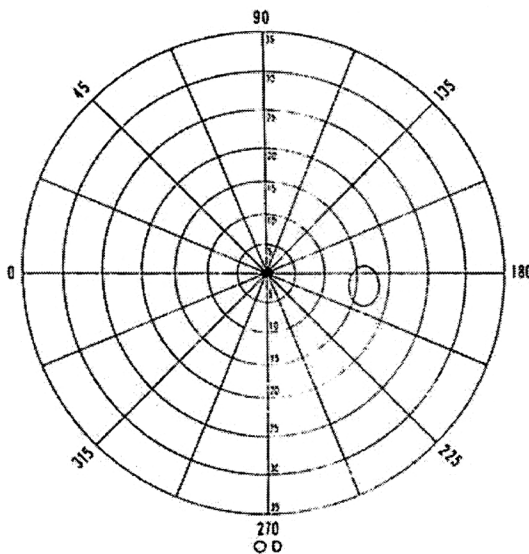
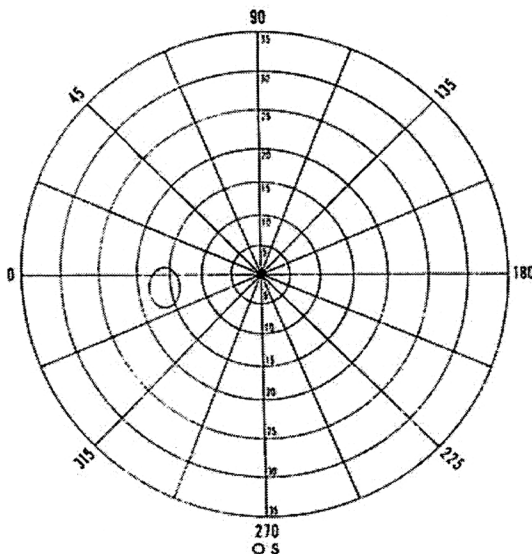
Intraocular pressure: _____

Is muscle function: ☐ normal? ☐ abnormal?, explain: _____

Is the child/student legally blind from a field restriction of 20 degrees or less? ☐ yes ☐ no

Is there a documented field loss? ☐ no ☐ yes (**record results below**) Test used: _____

Near Point of Convergence (NPC): _____ Positive Fusional Vergence (PFV): _____



V. **Recommended Treatment:** ☐ glasses ☐ patching ☐ medication ☐ surgery ☐ contacts ☐ safety glasses
☐ low vision evaluation ☐ other/comments: _____

Glasses: ☐ worn constantly ☐ distance only ☐ near only ☐ sunglasses ☐ tinted lenses

Was an optical device recommended? ☐ no ☐ yes

Specify type/power: ☐ telescope power ____ ☐ magnifier power ____ ☐ other: _____

Precautions or suggestions: (e.g., lighting conditions, activities to be avoided, etc.) _____

☐ Can participate in Goal Ball as a sport.

Examiner's Signature: _____ Date: _____