CONFIDENTIAL

EYE REPORT FOR CHILDREN WITH VISUAL PROBLEMS

This form is designed to elicit information on a small number of visually impaired students who may require specialized support services from a Consultant for the Visually Impaired, Program and Student Services Branch, Manitoba Education, Citizenship and Youth. Personal data to be completed by school or parent. Medical (eye) information to be completed by eye doctor. Consent to release information to Manitoba Education, Citizenship and Youth **MUST** be signed by parent (guardian) on reverse. Manitoba Education, Citizenship and Youth is prepared to secure the medical information from the eye doctor providing that the parent signs the release and provides the name and address of the eye doctor.

Name of Student: ______________________ Date of Birth: ______________________
(month) (day) (year)

Home Address: ____
(No. and Street) (City/Town) (Postal Code)

School: ____

DIAGNOSIS, ETIOLOGY & HISTORY

A. DIAGNOSIS of present ocular condition: ______________________

B. ETIOLOGY or underlying cause: ______________________

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

D. Probable AGE OF ONSET of visual impairment - right eye (O.D.) ______________________
- left eye (O.S.) ______________________

E. Has student's ocular condition occurred in any blood relative? __________ Relationship? __________

MEASUREMENTS

A. **VISUAL ACUITY:**

	Distance Vision		Near Vision	
	Without Correction	With Best Correction	Without Correction	With Best Correction
Right eye (O.D.)	______	______	______	______
Left eye (O.S.)	______	______	______	______
Both eyes (O.U.)	______	______	______	______

B. **FIELD OF VISION:** Is there a limitation? __________ If so, please describe including degrees of remaining visual field ______________________

PROGNOSIS AND RECOMMENDATIONS

A. Is student's vision impairment considered to be: stable ______ deteriorating ______ capable of improvement ______ uncertain ______

B. What TREATMENT is ongoing, if any? ______________________________

C. When is RE-EXAMINATION recommended? ______ months ______ yearly ______ never

D. GLASSES: not needed ______ wear part of the time ______ to be worn most of the time ______ If so, specify ______________________________

____

E. LIGHTING requirements: average ______ better than average ______ less than average ______

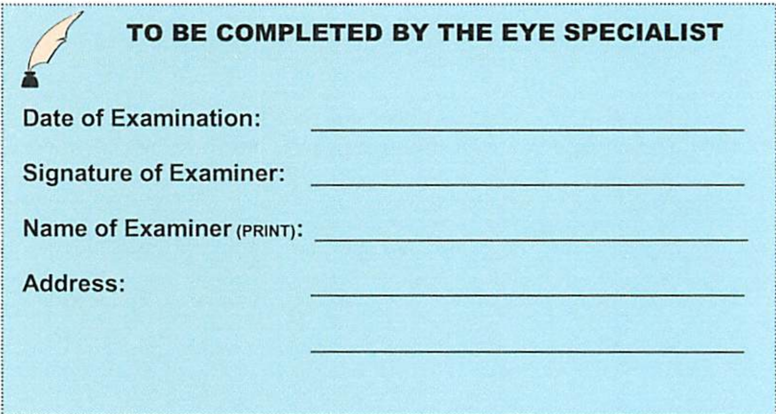
F. Does the present condition necessitate limited use of vision? __________ Specify ______________________________

____

G. PHYSICAL ACTIVITY: unrestricted ______ Restricted as follows: ______________________________

____

____



TO BE COMPLETED BY THE EYE SPECIALIST

Date of Examination: ______________________________

Signature of Examiner: ______________________________

Name of Examiner (PRINT)**:** ______________________________

Address: ______________________________

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I hereby authorize the doctor to submit the above report to Manitoba Education, Citizenship and Youth and realize this information will be shared with my child's school.

____
Signature of Parent (Guardian)

PLEASE RETURN COMPLETED FORM TO:

MARK ROBERTSON
MANITOBA EDUCATION, CITIZENSHIP AND YOUTH
PROGRAM AND STUDENT SERVICES BRANCH
206 – 1181 PORTAGE AVENUE
WINNIPEG, MB R3G 0T3