

EYE REPORT

FOR CHILDREN WITH EYE CONDITIONS

CONFIDENTIAL

This form is designed to elicit information on a small number of students with visual impairments who may require specialized support services from a Consultant for the Blind and Visually Impaired, Inclusion Support Branch, Manitoba Education and Training. 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 and Training MUST be signed by parent (guardian) below. Manitoba Education and Training 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.

PERSONAL DATA (data to be completed by school or parent):

Name of Student: _____ Date of Birth: _____
(month/day/year)

Home Address: _____
(P.O. Box and/or Street) (City/Town) (Postal Code)

School: _____

Eye Doctor: _____

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

Signature of Parent (Guardian)

ONCE COMPLETED/SIGNED BY PARENT/GUARDIAN – PLEASE SEND FORM TO:

Coordinator, Blind/Visually Impaired Services Unit
Manitoba Education and Training
Healthy Child Manitoba Office and K-12 Education Division
Inclusion Support Branch
204 – 1181 Portage Avenue
Winnipeg MB R3G 0T3
Fax: 204-948-3229

MEDICAL/EYE INFORMATION TO BE COMPLETED BY EYE DOCTOR

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 _____
- left eye _____

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

F. Is Nystagmus present? Yes _____ No _____

MEASUREMENTS:**A. Visual Acuity:****Distance Vision****Near Vision**Without CorrectionWith Best CorrectionWithout CorrectionWith 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 (please circle): stable deteriorating capable of improvement uncertain**B.** What TREATMENT is ongoing, if any? _____**C.** When is RE-EXAMINATION recommended? _____ weeks _____ months _____ never**D.** GLASSES: not needed _____
to be worn most of the time _____**E.** LIGHTING requirements: average _____ better than average _____ less than average _____**F.** PHYSICAL ACTIVITY unrestricted _____ restricted as follows: _____**G.** ADDITIONAL INFORMATION (e.g., prosthetic eyes): _____

**Date of Examination:** _____**Signature of Examiner:** _____**Name of Examiner (PRINT):** _____