CONFIDENTIAL

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

OCULAR REPORT

NAME	SEX	DATE OF BIRTH

ADDRESS (Street, City, Zip Code)	PARENT OR GUARDIAN	PHONE

ATTENDANCE SCHOOL DISTRICT (Name and Number)	RESIDENT SCHOOL DISTRICT (Name and Number)	GRADE

OVERALL DIAGNOSIS/ETIOLOGY

RE/_____

_____

LE/_____

_____

Does the child have a cerebral/cortical visual impairment? ☐ Yes ☐ No ☐ Suspect

FILL IN BOTH DISTANT AND NEAR VISION

DISTANT VISON			**NEAR VISION**		**PRESCRIPTION**			
VISUAL ACUITY	Without Correction	With Best Spectacle Correction	Without Correction	With Best Spectacle Correction	SPH.	CYL.	AXIS	ADD
Right Eye								
Left Eye								
Both Eyes								
Testing Instrument Used					Date of Above RX			

If the acuity cannot be measured enter an X to include the most appropriate estimation of visual acuity:

☐ Functionally Blind ☐ Low Vision ☐ Legally Blind

- Functionally Blind: In examiner's opinion, student's vision is 20/200 or less in better eye with maximum correction
- Low Vision: Distant acuity of 20/70 to 20/199
- Legally Blind: Central visual acuity of 20/200 or less in the better eye with correction or peripheral field no greater than 20°

VISION PROGNOSIS

Student's vision impairment is considered to be:

☐ Stable ☐ Capable of Improvement ☐ Progressing ☐ Fluctuating ☐ Uncertain

VISUAL FIELD RESTRICTION? ☐ Yes ☐ No

If yes, widest remaining visual field (in degrees) RIGHT_____ LEFT_____

Significant Field Restriction (please describe)_____

_____

IMPAIRED COLOR PERCEPTION? ☐ Yes ☐ No Which colors?_____

Student's Name: _____

ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

TREATMENT RECOMMENDED

☐ Medication (List):_____

☐ Surgery (Describe):_____

☐ Glasses ☐ Contact Lenses

☐ Constant Wear ☐ Near Vision Only ☐ Far Vision Only

☐ Occlusion

RE____ LE____ Type of Occlusion_____ Amount of time per day_____ Duration of Treatment_____

☐ Low Vision Aid Prescribed:

Distant: Type_____ RE_____ LE_____

Near: Type_____ RE_____ LE_____

☐ Lighting Requirements

☐ Average ☐ Other_____

☐ Restricted Physical/Recreational Activities

☐ No Restrictions ☐ Specify Restrictions:_____

RE-EXAMINATION ADVISED

☐ Six Months ☐ Twelve Months ☐ Other_____

TYPE OF EXAMINER

☐ Ophthalmologist ☐ Optometrist ☐ EENT ☐ Other M.D. (specify)_____

_____ _____

NAME OF EXAMINER **DATE OF EXAMINATION**

_____

STREET ADDRESS **CITY** **ZIP**

_____ _____ _____

PHONE ***Signature of Examiner*** ***Date***

Permission granted to use this information for purposes stated.

- To serve school administrators and special educators in determining school placement for students with visual impairments.
- To register all legally blind* students (excluding college) with the American Printing House for the Blind, Inc.
- To document eligibility of students who are visually impaired.
- To determine eligibility of all post high school persons requesting materials from the Services for the Visually Impaired.
- To be used by the Illinois Department of Public Health in registering persons with significant visual impairments.

_____ _____

Signature of Parent ***Date***

TO BE FORWARDED BY EXAMINER
TO: