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____

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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.

____

____

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____

____

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): ____

____

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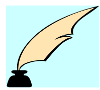

Date of Examination: ________________________

Signature of Examiner: ____

Name of Examiner (PRINT): ____