Otsego Northern Catskills BOCES
Itinerant and Related Services

Kimberlea E. Curran, Supervisor
Otsego Area Occupational Center
1914 Cty Rte 35 Milford, NY 13807
607-286-7715 ext 2608/2701
607-286-9603 Fax

FUNCTIONAL VISION EVALUATION REFERRAL FORM

Student Information Sheet

Student's Name:_____ DOB:_____

Parent(s) Name:_____

Address:_____

Phone Number: (home) _____ (work) _____

School District:_____ Phone:_____

Building:_____

Principal:_____

Teacher:_____ Grade:_____

Handicapping condition(s) if any:_____

_____

Person Making Referral:_____

Phone Number:_____

Reason for Referral:_____

_____

_____

_____

Does you child have an IEP? ___ Yes ___ No

If yes, what are your child's classification(s) as listed on the IEP? _____

_____

SERVICES FOR THE VISUALLY IMPAIRED

Medical History

Student's Name:_____

Identified eye condition(s):_____

_____

Visual Acuity:_____

Other handicapping condition(s) if any:_____

_____

Medications, if any:_____

Allergies, if any:_____

Eye Doctor:_____

Phone Number:_____

Date of most recent eye exam:_____

Please obtain and attach a copy of the doctor's most recent eye report.

Other related medical information:_____

_____

_____

_____

_____

updated *03/12/2020*

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Student Name: _____

Please place an X in the appropriate box.

☐ **Yes,**

I give you permission to do a Functional Vision Evaluation of my child and to speak to his/her teachers.

☐ **No,**

I do not give you permission to do a Functional Vision Evaluation of my child.

Please sign and date. Thank you.

Signature:_____

Date:_____

updated 03/12/2020