Clear Form Data

VISION REFERRAL FORM

Referral Contact Information:

School/District _____

Name of person making referral _____

Contact person information (phone, email) _____

Student Information:

Student _____ Birth Date _____ Age _____ Grade _____

Student lives with: ◯ parent ◯ grandparent ◯ foster parent ◯ other _____

Primary language spoken in home _____

Parent/Guardian Information:

Parents/Guardians Name _____

Address _____

Phone _____ Email _____

If student is living with someone other than a parent, please list who has educational rights.

_____

Reason for referral (Describe your vision concerns for this child. Be specific)

_____

_____

_____

_____

Health Information:

Diagnosed medical conditions _____

Current medications _____

Does the student wear glasses or contacts? ☐ Yes ☐ No

Name of eye doctor _____

Eye doctor contact information _____

Does the student have a hearing impairment? ☐ Yes ☐ No

Additional Information

Verified Special Educational (SPED) disabilities, if student on a current IEP _____

_____

Current SPED services? _____

Signature of person making referral _____

Position _____ Date_____

Signature of authorized school official _____

Position _____ Date_____