CONFIDENTIAL

OCULAR REPORT / INFORME OCULAR

NAME / NOMBRE	SEX / SEXO	DATE OF BIRTH / FECHA DE NACIMIENTO

ADDRESS (Street, City, Zip Code) / DIRECCIÓN (Calle, Ciudad, Código Postal)	PARENT OR GUARDIAN / PADRE O TUTOR	PHONE / TELÉFONO

ATTENDANCE SCHOOL DISTRICT (Name and Number) / DISTRITO ESCOLAR DE ASISTENCIA (Nombre y Número)	RESIDENT SCHOOL DISTRICT (Name and Number) / DISTRITO ESCOLAR DE RESIDENCIA (Nombre y Número)	GRADE / GRADO

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 VISION			**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			

FUNCTIONALLY BLIND: In examiner's opinion, acuity cannot be measured, and student presents as functionally blind. Students in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment (e.g., brain injury or dysfunction).

☐ Yes ☐ No

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: _____

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 / TIPO DE EXAMINADOR

☐ Ophthalmologist / Oftalmólogo ☐ Optometrist / Optometrista ☐ EENT / Doctor de Ojos, Oídos, Nariz y Garganta

☐ Other M.D. (specify) / Otro Doctor en Medicina (especifique)

_____ _____

Name of Examiner / Nombre del Examinador Date of Examination / Fecha del Examen

_____

Street Address / Dirección City, State / Ciudad, Estado Zip / Código Postal

_____ _____ _____

PHONE / TELÉFONO ***Signature of Examiner / Firma del Examinador*** ***Date / Fecha***

I give permission for this ocular report to be released to / Doy permiso para que este informe ocular se entregue a:

_____ _____

Name of District/Coop/Agency/Organization / Nombre del Distrito/Cooperativa/Agencia/Organización Attention to / Atención a:

_____

Street Address / Dirección City, State / Ciudad, Estado Zip / Código Postal

_____ _____

Email / Correo Electrónico Fax

_____ _____

Signature of Parent / Firma del Padre ***Date / Fecha***

Approved by IVLC November 2025