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Dear Ophthalmologist and/or Optometrist;

“The Federal Act to Promote the Education of the Blind”, enacted by Congress in 1879, requires school districts to have current (within 3 years) eye health care reports from an Optometrist, Ophthalmologist, or Neurologist on file in school districts in order to be eligible to be counted in the Federal Quota program, and to access learning materials from American Printing House for the Blind. Many times visual acuities are not obtainable for certain individuals, especially infants. Because of this, it is necessary to request the following information to determine whether a student meets the Federal guidelines of legal blindness in order to be counted in the Federal Quota program.

Child’s Name: ______________________________________ DOB: ________________

DOCTOR’S OFFICE TO COMPLETE THIS SECTION:

Based on the Eye Exam Date of: _________________, regarding the above mentioned child, if visual acuity cannot be measured, in your professional judgment, do you feel this person:

☐ Functions better than 20/200 corrected, in their best eye (***Snellen*** equivalent)

☐ Meets the Definition of Blindness – “MDB”

As defined in The Act: “Central visual acuity of 20/200 or less in the better eye with correcting glasses or a peripheral field so contracted that the widest diameter of such field subtends an angular distance no greater than 20 degrees,”

OR

☐ Functions at the Definition of Blindness – “FDB”

As defined in The Act: “When visual performance is reduced by a brain injury or dysfunction when visual function meets the definition of blindness as determined by an eye care specialist or neurologist. Chilrden in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment.”

In addition to the boxes above, the eye doctor may choose to check the box below:

☐ For eligibility into the annual federal quota census, this child meets or functions at the definition of blindness and **no further verification of legal blindness is necessary until this student graduates**.

This does NOT mean that this child never needs another eye exam!

Continued eye health care is recommended and necessary.

This simply means that the school district does not need to verify legal blindness again with the Colorado Instructional Materials Center while this student is enrolled in a public school system at less than college level.

____ ______________

Doctor Signature Date

Doctor’s Name (please print):____

Thank you for your time supporting Colorado children who have been identified with “Visual Impairment, Including Blindness”

Colorado Teachers of the Visually Impaired (TVIs)

DISTRICT PERSONNEL TO COMPLETE THIS SECTION:

Please return this form, when completed, to referrals@asharedvision.org or mail to:

A Shared Vision: Partners in Pediatric Blindness & Visual Impairment
10135 West 101st Drive
Westminster, CO 80021

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Dear Parent,

By your signature below, you agree to share your child's eye health information with both your school district and the Colorado Instructional Materials Center. As explained on the preceding page, this information is a requirement in determining eligibility for the Federal Quota program, and access to learning materials from American Printing House for the Blind.

____ ____________________
Parent Signature Date

Parent's Name (please print):____

******PARENT – PLEASE RETURN THIS FORM, SIGNED BY YOUR DOCTOR, TO YOUR SCHOOL DISTRICT FOR INCLUSION IN YOUR CHILD'S STUDENT RECORD*******

****

Querido Padre,

Por su firma abajo, usted consiente en compartir la información de salud de ojo de su niño tanto con su distrito escolar como con el Colorado Centro de Materiales Educacional. Como explicado en la página precedente, esta información es una exigencia en la determinación de la elegibilidad para el programa de Cuota Federal, y acceso al aprendizaje de materiales de la Casa de Imprenta americana para el Ciego.

____ ____________________
Fecha de Firma Paternal

El Nombre del Padre (por favor imprima): ____

****** EL PADRE – POR FAVOR DEVUELVA ESTA FORMA, FIRMADA POR SU DOCTOR, A SU DISTRITO ESCOLAR PARA LA INCLUSIÓN EN EL REGISTRO DE ESTUDIANTE DE SU NIÑO *******