BRUSH COUNTRY CO-OP

REQUEST FOR VISION EVALUATION / SERVICES

Date of Request: _____ ☐ Initial Evaluation ☐ Re-evaluation ☐ Special Request

Student: _____ Age: _____ DOB: _____ Grade: _____

District: _____ Campus: _____ Teacher: _____

EVALUATION

The above named student has been referred to Special Education for a Functional Vision Evaluation and Learning Media Assessment. Referral Information and observation indicate the following vision problem that prevents this student from benefiting from his present educational program.

Explain vision problem (include information from eye doctor, teachers, parents and student)**:**

Submit the following information:

- ✓ Referral Packet if initial referral into Special Education (referral must complete)
- ✓ Current eye report from Optometrist/Ophthalmologist
- ✓ Student's current schedule
- ✓ Current ARD, Assessments, IEPS if student is already in Special Education

SERVICES (i.e. transfer students)

The above named student has been diagnosed with a Visual Impairment and has previously received Vision services.

Submit the following information:

- ✓ Current eye report from Optometrist/Ophthalmologist
- ✓ Copy of all assessment reports including Functional Vision Evaluation
- ✓ ARD from previous school district including goals & objective
- ✓ Student's current schedule

_____ _____

Diagnostician Signature **Date**

_____ _____

Vision Teacher Signature **Date**

BCC