Mississippi Instructional Resource Center (MIRC)

Eye Report for Vision Services & APH Registration

MISSISSIPPI DEPARTMENT OF EDUCATION
Ensuring a bright future for every child

Section 1: Demographics

Student Name: _____**Grade**_____**DOB:**_____

District/School: _____**Date of Current Eye Exam:** _____

Section 2: Eligibility for Vision Services and Federal Quota Fund Registration (mark all that apply)

- ☐ **Visually Impaired (VI)** *20/70 or less in the better eye after correction or there is a limited visual field that could adversely affect educational progress.*
- ☐ **Meets the Definition of Blindness (MDB)** *20/200 or less in the better eye after correction or visual field no greater than 20 degrees.*
- ☐ **Meets the Definition of Blindness (MDB)** *Immutable Condition (bilateral enucleations, etc)*
- ☐ **Functions at the Definition of Blindness (FDB)** *Students in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment.*

Section 3: Visual Diagnosis & Prognosis

Diagnosis: _____

Prognosis: ☐ stable ☐ capable of improving ☐ progressive ☐ uncertain

Section 4: Acuities & Visual Fields *If unable to obtain Snellen Acuity, consider the FDB criteria*

	Distance Acuity (ft.)			Near Acuity (in.)		
	O.D. (right)	**O.S. (left)**	**O.U. (both)**	**O.D. (right)**	**O.S. (left)**	**O.U. (both)**
Corrected						
Without Correction						

Counts Fingers: ☐ O.D ☐O.S **Hand Movement:** ☐ O.D ☐O.S
Object Perception: ☐ O.D ☐O.S **Light Perception:** ☐ O.D ☐O.S

Is there a field limitation? ☐ Yes ☐No If yes, please describe: _____
Please attach diagram of visual fields if tested.

Section 5: Prescription *Complete if glasses and/or contact lenses prescription issued*

OD: sphere _____ Cylinder _____ Axis _____
OS: sphere _____ Cylinder _____ Axis _____
Glasses: ☐ To be worn constantly ☐ for close work only ☐ for distance only ☐ for protection

Section 6: Ocular Surgery, Medications

Section 7: Recommendations (Large Print/Braille Materials, Visual Aids, Physical Restrictions, etcs…)

Section 8: Authorizations

Doctor's Name Printed: _____Name of Practice: _____
Doctor's Signature:_____ MD OD
Parent/Guardian Signature:_____ Date: _____
I authorize the doctor listed above to release this information for educational purposes.