Dear Optometrist and/or Ophthalmologist,

"The Federal Act to Promote the Education of the Blind", enacted by Congress in 1879, requires school districts to have a current (as defined by your state) eye report 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 the American Printing House for the Blind.

Many times visual acuities are not obtainable for certain individuals. 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.

****

Student Name: _____ DOB:_____

DOCTOR'S OFFICE TO COMPLETE THIS SECTION:

Based on Exam Date: _____, regarding the above mentioned student, 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 - "MOB"

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 - "FOB"

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. Students in this category manifest unique visual characteristics often found in conditions referred to as neurological,cortical, or cerebral visual impairment."

_____ _____
Doctor Signature Date

Doctor's Name (please print): _____

Thank you for your time and support!

DISTRICT PERSONNEL TO COMPLETE THIS SECTION:

Please return this form when completed to: _____
Teacher of the Visually Impaired (TVI)

District/Agency_____Fax: _____

Address: _____

Dear Parent,

By your signature below, you agree to share your child's eye health information with both your school district and the _____. 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 cornpartir la informaci6n de salud de ojo de su nino tanto con su distrito escolar como con el _____. Como explicado en lapagina precedente, esta informaci6n es una exigencia en la determinacion de la elegibilidad para elprograma 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 DISTRITOESCOLAR PARA LA INCLUSI6N EN EL REGISTRO DE ESTUDIANTE DE SU NINO*** ****