Children's Low Vision Project of British Columbia (CLVP-BC)

Parent/Guardian Form

Student Name (First, Last)

Date of Birth

Parent/Guardian Name (First, Last)

Relationship to Student

Section A: Medical Information

BC Care Card Number

Name of Family Doctor or Pediatrician

Wears glasses? If yes, what is age of current glasses?

Name of Ophthalmologist

Date of Last Ophthalmology Appt

What is the cause of your child's vision loss? (i.e., name of condition)

At what age was this condition identified?

Please note any additional visual conditions

Explain any treatment or surgery related to your child's visual condition.

Please list any medications your child is currently taking related to their visual condition(s). Please also indicate how often the medication is taken.

Please send this completed referral as an email attachment to clvp@prcvi.org.

CLVP is hosted by the Provincial Resource Centre for the Visually Impaired (PRCVI)

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Section B: Medical History

Please note any details about your child's birth history that are relevant to their visual condition(s).

Was your child born prematurely?	If premature, what was your child's gestational age?
Is your child in overall good *physical* health?	If there are concerns, please specify
Is your child in overall good *mental* health?	If there are concerns, please specify

Please note the presence of any of the following in your child's family history

Blindness	Cataracts in Childhood
Amblyopia ("lazy eye")	Glaucoma in Childhood
Strabismus ("crossed eye")	Complications from anesthesia
Eye Muscle Surgery	Genetic disease (runs in family)

Other serious illness (please list)

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Section B: Educational and Social History

Who does your child share a home with? Please check all that apply.

Parents/Guardian(s) **Grandparent(s)**

Sibling(s) **Extended Family** **Other(s)** ______________________

Does your child use screens (e.g., TV, gaming)?

If yes, at what distance? ______________________

What media does your child use to read? Please check all that apply.

Braille **Standard Print** **Large Print** **Audio** **Other** __________________

Does your child use any tools (e.g., magnifiers) or devices (e.g., tablet, laptop computer) to access learning materials? Please note these below:

In your experience, how does your child's visual condition impact their ability to function in the following settings?

At home:

At school:

In the community:

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Is your child currently served by a Teacher of Students with Visual Impairments (TSVI)?

TSVI Name: ____

Is your child currently served by an Orientation and Mobility (O&M) Specialist?

O&M Specialist Name: ___________________________________

Please have your child bring to the Clinic their **PRESCRIPTION GLASSES** (if they wear glasses) and any **OPTICAL AIDS** they are presently using for near and distance viewing, as well as any devices that they received at a previous CLVP clinic.

PLEASE NOTE: Parents/Guardians should be prepared to stay for the entire CLVP appointment, which can run up to 2-3 hours per student.

PHOTO PERMISSION - FILE

May the CLVP team take a photo of your child to include in their CLVP client file?

PLEASE BRING YOUR CHILD'S BC CARE CARD WITH YOU TO THE APPOINTMENT.

This form must be returned at least three weeks prior to the CLVP appointment to hold your child's clinic space. Please email an electronic copy to clvp@prcvi.org.

PARENT/GUARDIAN SIGNATURE: ___________________________________

PARENT/GUARDIAN EMAIL ADDRESS:

PARENT GUARDIAN PHONE NUMBER:

DATE: _________________________

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