Children's Low Vision Project of British Columbia

BRINGING COMPREHENSIVE LOW VISION ASSESSMENT SERVICE TO BRITISH COLUMBIA CHILDREN

Central Okanagan Public Schools
Together We Learn

EDUCATOR FORM

THIS FORM MUST BE COMPLETED & RETURNED 3 WEEKS PRIOR TO CLINIC TO KEEP YOUR CHILD'S APPOINTMENT

Student Name:	DOB:	Gender:
Address:		
City:	Province:	Postal Code:
Parent/Guardian:	Phone:	
Vision Teacher: & Job Title	Email:	
Address of Vision Teacher: *Street* *City* *Postal Code*	Contact phone for Vision Teacher:	

Achievement/Academic Level:_____Grade or School Placement:_____

School Name:_____School District #:_____

School Address _____
Street City Postal Code

Referring Teacher's Name: Phone:_____

Length of time you have worked with the student:_____

Name of school personnel who will accompany the student:_____

What support does the student receive? ☐ OT ☐ PT ☐ Speech

☐ O&M Frequency?_____

☐ Classroom aide # of hours per day?_____ and what subjects?_____

_____

VISUAL FUNCTION

Eye condition _____ Visual Acuity_____

Primary reading modality: *(please ☑)*

☐ Braille ☐ Large Print ☐ Regular Print ☐ Etext ☐ Computers

Is the student certified with PRCVI? ☐ Yes ☐ No

Does the student receive any large print material or any alternate format material from the Provincial Resource Center (PRCVI) in Vancouver? ☐ Yes ☐ No

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OPTICAL DEVICES:

Does the student wear eye glasses? ☐ Yes ☐ No

Does the student have optical devices (magnifiers/monoculars) of any kind? ☐ Yes ☐ No

Please specify what type of magnifier (dome, bar, slice etc) or monocular are used and the magnification of (2x, 4x etc):

Magnifier: type _____ magnification _____

type_____ magnification _____

Monocular: type _____ magnification _____

These devices were provided by: ☐ CLVP-BC ☐ School District / Vision Teacher

Please describe what classroom tasks these optical devices are used for and how often they are used:

ASSISTIVE TECHNOLOGY:

Does the student have any assistive technology? ☐ Yes ☐ No

The assistive technology was provided by : ☐ SET-BC ☐ School District ☐ Family

Please list all the assistive technology (hardware and software) used by this student:

Please describe what tasks the assistive technology is used for and how often:

CLASSROOM / SCHOOL INFORMATION:

Specifically, what difficulties does this student have at school due to their vision loss? Consider the classroom and school environment, the teaching /learning materials, the playground, and social skills in your response.

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What does the student's school-based team hope to gain from the CLVP-BC assessment process? **(Classroom teacher OR Resource teacher may also fill this section out).**

Please provide any additional information to help us understand this student and their needs.(attach an additional sheet if needed)

This information **must be returned** to Teri Schmidt **three weeks prior to Clinic date** to keep the appointment.
Please scan & e-mail, or fax this form to:

Teri Schmidt, Administrative Assistant
Children's Low Vision Project of British Columbia
Phone (250) 870-5145 Fax (250) 870-5080
teri.schmidt@sd23.bc.ca

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