



# 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:<br><i>Street</i> | <i>City</i> | <i>Postal Code</i> | Contact phone for Vision Teacher: |         |

Achievement/Academic Level: \_\_\_\_\_ Grade or School Placement: \_\_\_\_\_ Modified Program: \_\_\_\_\_

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 therapy  
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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Student Name: \_\_\_\_\_

## 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 \_\_\_\_\_ used for: \_\_\_\_\_

                                 type \_\_\_\_\_ magnification \_\_\_\_\_ used for: \_\_\_\_\_

                                 Monocular: type \_\_\_\_\_ magnification \_\_\_\_\_ used for: \_\_\_\_\_

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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Student Name: \_\_\_\_\_

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](mailto:teri.schmidt@sd23.bc.ca)

