



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: <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 the CLVP Resource Secretary **three weeks prior to Clinic date** to keep the appointment. Please scan & e-mail, or fax this form to:

CLVP Resource Secretary
Children's Low Vision Project of British Columbia
Phone (250) 860-8888 Fax (250) 870-5080
clvpbc@sd23.bc.ca

