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

PARENT FORM

Name of Child:____Male ☐ Female ☐

Date of Birth:____**BC Medical #:**_____

Parent / Guardian:____Relationship to Child:_____

Home Phone:____Work Phone:______________________________

Address:____

Street City Postal Code

E-mail address:____

Family MD or Pediatrician ____

BIRTH HISTORY:

Birth weight ___________lbs.,___________oz. Gestational age (if premature)____________weeks

☐ Problems during pregnancy

☐ Problems during delivery or forceps delivery

☐ Baby kept in hospital due to illness

☐ Delivered early (how early? _______

☐ Cesarean section(why?____

☐ Delays in development

FAMILY HISTORY:

☐ Blindness

☐ Amblyopia ("lazy eye")

☐ Strabismus ("crossed eye")

☐ Eye muscle surgery

☐ Glasses before age 6

☐ Cataracts in childhood

☐ Glaucoma in childhood

☐ Complications from anesthesia

☐ Genetic disease (runs in family)

☐ Other serious illnesses (please list)

EYE PROBLEMS:

☐ Eye Injury____

☐ Eye Surgery____

☐ Eye Disease____

☐ Glasses How old are glasses? ____________________________

SOCIAL HISTORY:

Patient lives with: ☐ Parents ☐ Relative ☐ Other_____________________________________

Names and ages of brothers and sisters:____

____

____

MEDICAL HISTORY:

Is your child in good physical health? ☐Yes ☐No (*please specify)*_____________________________

List the medications your child is currently taking and any special medical treatments:___________________

____

Has your child had previous surgeries, hospitalizations, major illnesses, or injuries: ☐Yes ☐No (if yes, *please specify)*

____

____

PARENT FORM

Does your child experience difficulties at ☐ school, due to vision ☐ home, due to vision?

Please describe:____________________________________

VISUAL HISTORY:

Name of Eye Doctor:______________________ Date of last appointment:____________

Address of Eye Doctor:____________________________________

____________________________ Office Phone #:________________

What is the cause of your child's visual loss? (i.e.: eye condition)________________

Explain any treatment, medication, or surgery related to your child's eye condition:_

____

At what age did your child's vision loss occur? ________________________

Which eye seems to be your child's better eye? ☐ Right ☐ Left ☐ No difference

Explain any recent changes in your child's vision: _

____

VISUAL FUNCTIONING:

Does your child watch TV or play Video Games? ☐ Yes ☐ No at what distance? ________________

Does your child see better or more comfortable on: ☐ bright sunny days OR ☐ overcast/cloudy days

Is your child bothered by glare? ☐ Yes ☐ No

Does your child use sunglasses, a visor, or a hat? ☐ Yes ☐ No

Does your child use a magnifying glass or other devices for reading? ☐ Yes ☐ No If yes, please describe ________

____

Does your child use any of the following:

☐ Braille ☐ Talking Books ☐ Readers ☐ Tapes ☐ Computers ☐ Closed-Circuit TV

ORIENTATION & MOBILITY:

Does your child receive orientation and mobility services? ☐ Yes ☐ No

Name of O&M instructor: ________________________

Your child's low vision report will be mailed to you and to the School District. Please list additional persons or offices that you may want this report to be sent: **(ADDRESSES MUST BE COMPLETE)**

____

Name Street Address City, Province, Postal Code

____

Name Street Address City, Province, Postal Code

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Name Street Address City, Province, Postal Code

____

Name Street Address City, Province, Postal Code

PARENT FORM

NB: Please have your child bring to the Clinic his/her **PRESCRIPTION GLASSES** (if they wear glasses) and any **OPTICAL AIDS** they are presently using.

Parents should be prepared to stay for the entire clinic appointment.
This can take up to 2 - 3 hours per student.

____
Parent/Guardian Signature

PLEASE NOTE: BRING THE BC MEDICAL CARD WITH YOU TO THE CLINIC
FORM MUST BE RETURNED 3 WEEKS PRIOR TO THE CLINIC TO KEEP YOUR CHILD'S APPOINTMENT

Return this form to Teri Schmidt, at least THREE WEEKS prior to the clinic date to keep the appointment.
Please scan & email, 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