



**PARENT FORM**

Name of Child: \_\_\_\_\_ Male  Female

Date of Birth: \_\_\_\_\_ BC Medical #: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell 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  Delivered early (how early?) \_\_\_\_\_

Problems during delivery or forceps delivery  Cesarean section (why?) \_\_\_\_\_

Baby kept in hospital due to illness  Delays in development

**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)

Glasses before age 6  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)  
\_\_\_\_\_

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Name of child: \_\_\_\_\_

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  Large Print Regular Print Etext Computers Audio Books

## **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

Name Street Address City, Province, Postal Code

Name Street Address City, Province, Postal Code

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Name of child: \_\_\_\_\_

**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, including monocular devices, ipad, as well as any devices that they received at a previous CLVP clinic.

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

