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:_____ 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
- ☐ 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

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
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PARENT FORM

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

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