



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

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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 the CLVP Resource Secretary, at least **THREE WEEKS** prior to the clinic date to keep the appointment. Please scan & email, 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

