

Student Accessibility  
800 Main Street, room C-022  
Pewaukee, WI 53072  
262.691.5318 (Phone)  
262.691.5089 (Fax)

# Visual Impairment or Blindness Certification

The student named below has applied for services from the Student Accessibility area at WCTC. In order to provide reasonable and appropriate services for students with visual disabilities, current and comprehensive information documenting the functional impact of the disability is required. This form is intended to assist the Student Accessibility staff in providing sufficient information so that eligibility for services can be determined. The information you provide will not become part of the student's educational records and will be kept in the student's confidential file. In addition to the requested information, please attach any additional information; for example, your report and any test results. Thank you for your assistance.

1. Student name \_\_\_\_\_ Date \_\_\_\_\_

2. Date of your last contact with student \_\_\_\_\_

### 3. DIAGNOSIS

Eye pathology (primary and secondary conditions): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is patient's present correction adequate? \_\_\_\_\_

Precautions that should be taken in training: \_\_\_\_\_

4. Please indicate medications that have been prescribed for this student.

Medication(s), dosage, and date first prescribed \_\_\_\_\_

5. What methods or testing instruments did you use to arrive at your diagnosis? Please check all relevant items adding brief notes that you think might be helpful to us as we determine which accommodation services are appropriate for the student.

- Structured or unstructured clinical interviews with the individual
- Interviews with other individuals
- Developmental history
- Medical history
- Vision testing – date(s) of testing? \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

6. Please indicate which accommodations, if any, may be beneficial to this student. \_\_\_\_\_  
\_\_\_\_\_

7. Is there anything else you would like us to know about this student? \_\_\_\_\_  
\_\_\_\_\_



Visual Impairment or Blindness (continued)

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8. Report of Examination

Visual Acuity - Snellen Notations (20 feet for distance; 14 inches for reading):

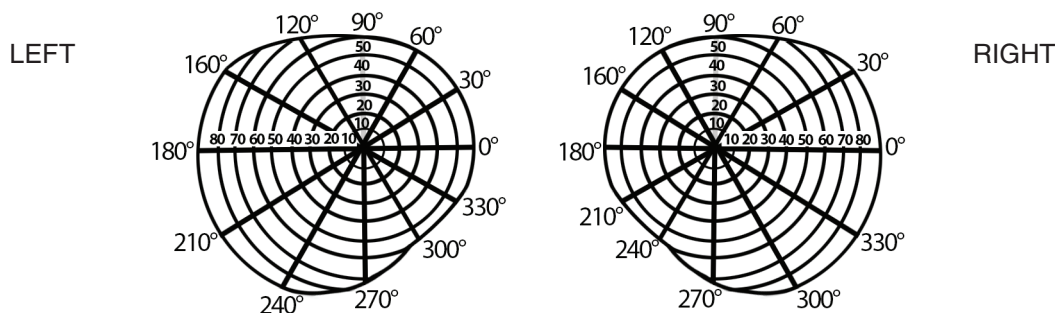
<b>Without correction</b> {	Right eye D. _____ R. _____	<b>With best correction</b> {	Right eye D. _____ R. _____
	Left eye D. _____ R. _____		Left eye D. _____ R. _____

(If necessary, state vision in terms of light perception, light projection, hand movements, or ability to count fingers.)

**Refraction Record:** Right eye (prescription) \_\_\_\_\_ Left eye (prescription) \_\_\_\_\_

**Visual Fields:** Do not make detailed test unless indicated by preliminary test. Please state method used: \_\_\_\_\_

Central scotomata may also be plotted below.



**Muscle Function:** Do not make detailed test unless indicated by preliminary test.  
 Normal \_\_\_\_\_ Restricted \_\_\_\_\_ If restricted, describe under pathology.

**Binocular Function:** Does patient have useful binocular vision in all directions *with glasses*?  
 For distance \_\_\_\_\_ For near \_\_\_\_\_

If patient does not have useful binocular vision, give reason and explain any handicap arising therefrom.

Is depth perception present? \_\_\_\_\_

Color Perception: Normal \_\_\_\_\_ Deficient \_\_\_\_\_

If deficient, for what colors? \_\_\_\_\_

Signature of professional \_\_\_\_\_ Date \_\_\_\_\_

Medical professional's name (printed) and title \_\_\_\_\_

License number \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_