Mississippi Instructional Resource Center (MIRC)

Eye Report for Vision Services & APH Registration

Section 1: Demographics

Student Name: ________________________________Grade_____________DOB:__________________

District/School: ____________________________________Date of Current Eye Exam: _____________

Section 2: Eligibility for Vision Services and Federal Quota Fund Registration (mark all that apply)

- ☐ **Visually Impaired (VI)** *20/70 or less in the better eye after correction or there is a limited visual field that could adversely affect educational progress.*
- ☐ **Meets the Definition of Blindness (MDB)** *20/200 or less in the better eye after correction or visual field no greater than 20 degrees.*
- ☐ **Meets the Definition of Blindness (MDB)** *Immutable Condition (bilateral enucleations, etc)*
- ☐ **Functions at the Definition of Blindness (FDB)** *Students in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment.*

Section 3: Visual Diagnosis & Prognosis

Diagnosis: ____

Prognosis: ☐ stable ☐ capable of improving ☐ progressive ☐ uncertain

Section 4: Acuities & Visual Fields *If unable to obtain Snellen Acuity, consider the FDB criteria*

	Distance Acuity (ft.)			Near Acuity (in.)		
	O.D.	**O.S.**	**O.U.**	**O.D.**	**O.S.**	**O.U.**
Corrected						
Without Correction						

Counts Fingers: ☐ O.D ☐O.S **Hand Movement:** ☐ O.D ☐O.S
Object Perception: ☐ O.D ☐O.S **Light Perception:** ☐ O.D ☐O.S

Is there a field limitation? ☐ Yes ☐No If yes, please describe: _________________________________
Please attach diagram of visual fields if tested.

Section 5: Prescription *Complete if glasses and/or contact lenses prescription issued*

OD: sphere _________ Cylinder __________ Axis _________
OS: sphere _________ Cylinder __________ Axis _________
Glasses: ☐ To be worn constantly ☐ for close work only ☐ for distance only ☐ for protection

Section 6: Ocular Surgery, Medications

Section 7: Recommendations (Large Print/Braille Materials, Visual Aids, Physical Restrictions, etcs…)

Section 8: Authorizations

Doctor's Name Printed: ________________________________Name of Practice: ____________________
Doctor's Signature:____ MD OD
Parent/Guardian Signature:____ Date: ____________________
I authorize the doctor listed above to release this information for educational purposes.