**St. Johns County School District**
**Exceptional Student Education**
**40 Orange Street, St. Augustine, FL 32084 (904) 547-7672**

# EYE MEDICAL INFORMATION AND CERTIFICATION FORM

| Name of Student: | D.O.B.: |
|---|---|
| School: | Grade: |
| Name of Parent or Guardian: | |
| Address: | |
| Email: | Phone: ( ) |

I give permission for the examiner and school district personnel to exchange pertinent information pertaining to my child's condition.

Parent/Guardian Signature______________________________________________ Date:________________

**The Florida State Board of Education Rule 6A-6.03014 Exceptional Student Education Eligibility for Students Who Are Visually Impaired mandates the following medical criteria must be present:**

**MUST BE COMPLETED IN ITS ENTIRETY BY A LICENSED OPTHALMOLOGIST OR OPTOMETRIST**

**Diagnosis:** ______________________________

**Etiology:** ______________________________

**Prognosis:** ☐ Permanent ☐ Stable ☐ Deteriorating ☐ Can Improve ☐ Unable to determine

**Visual Acuity:** Complete the box below using Snellen equivalents or NLP, LP, CF, HM, F and F, CSM.

| Without Correction | | With Best Correction | |
|---|---|---|---|
| **Distance (20ft)** | **Near (16in)** | **Distance (20ft)** | **Near (16in)** |
| **OS** | **OS** | **OS** | **OS** |
| **OD** | **OD** | **OD** | **OD** |
| **OU** | **OU** | **OU** | **OU** |

If the acuity cannot be measured, please select the most appropriate estimation:

☐ Legally Blind 20/200 or worse

☐ Between 20/70 and 20/199

☐ Better than 20/70

☐ Functions at the Definition of Blindness (e.g. CVI)

**Visual Fields:**

☐ 21 to 30 degrees ☐ 20 degrees or less

☐ Unable to determine ☐ No apparent field loss

**Describe:** Central or Peripheral

**Muscle Function:** ☐Normal ☐Abnormal ☐Describe:____________________________________
**Treatment Regimen:** ______________________________________________________________
**Prescribed Glasses:** ☐None ☐Close work only ☐Distance only ☐Worn constantly
**Prescribed Contact Lenses:** ☐Yes ☐No Prescribed Low Vision Aids: ☐Yes ☐No
**Clinical Low Vision Evaluation Recommended:** ☐Yes ☐No

| **Precautions or suggestions (e.g., lightning conditions, physical activities to be avoided, etc.):** |
|---|
| |

**A licensed ophthalmologist or optometrist must indicate at least one of the criteria below that best describes the patient's visual functioning:**

| Physician Initials | | |
|---|---|---|
| __________ | ☐ | A visual acuity of 20/70 or less in the better eye after the best possible correction |
| __________ | ☐ | A peripheral field so constricted that it affects the student's ability to function in an educational setting |
| __________ | ☐ | A diagnosis of visual impairment after the best correction |
| __________ | ☐ | A progressive loss of vision that may affect the student's ability to function in an educational setting |
| __________ | ☐ | None of the above |

**Date of Exam:** __________________ **Date form completed:** ________________

____________________________________
Physician's Signature

____________________________________
Physician's Medical License Number

____________________________________
Print Physician's Name

____________________________________
Date Completed

____________________________________
Office Telephone Number

____________________________________
Office Fax Number

**Please return the completed form to:**

| Name:<br>Avery Greene, ESE Program Specialist | Address:<br>40 Orange Street<br>St. Augustine, Florida 32084 |
|---|---|
| Fax:<br>904-547-7544 | Phone:<br>904-547-7712 |