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)**
OD	**OD**	**OD**	**OD**
OS	**OS**	**OS**	**OS**
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:_____
Eye Pressure: OD _____ OS _____
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 Name of Clinic

_____ _____
Print Physician's Name Date Completed

_____ _____
Office Telephone Number Office Fax Number

Please return the completed form to:

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