Date: _____

Referral of Student with Possible Visual Impairment

Name of Student:_____

Age of Student: ____ Grade of Student: ___

Birthdate: _____

School: _____

Parent/Guardian Names:

_____

Person Making the Referral:_____

Relation to the Student: _____

Phone Number:_____

Email Address:_____

District Supervisor's Signature:

_____

Describe what you are seeing that made you question the child's visual function:

Have you contacted the parent/guardian regarding your concern?

Yes ◯ No ◯

Does this child presently have an IEP or 504 plan?

Yes ◯ No ◯

If you have a vision evaluation or eye doctor report (and have permission to share), please attach.

Please return this document to:

Mail:
Kalamazoo RESA VI Staff
c/o Shelly Hawthorne
Coordinator for DHH and VI Programs
1501 East Milham Avenue,
Portage, MI 49002
Attention: VI Referral
OR
Email attached document to:
Shelly.hawthorne@kresa.org

PRINT