Student Accessibility
College Center, Room C-019
800 Main Street, Pewaukee, WI 53072
Voice/Relay: 262.691.5318 | Fax: 262.691.5089
SAO@wctc.edu

Visual Impairment or Blindness Certification

The student named below has applied for services from the Student Accessibility Office 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.

Please print legibly

1. Student's name _____ Date _____

2. Date of your last contact with student _____ Student's DOB _____

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? _____

_____

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Visual Impairment or Blindness *(continued)*

8. Report of Examination

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

Without correction { Right eye D. _____ R. _____ / Left eye D. _____ R. _____ }

With best correction { Right eye D. _____ R. _____ / Left eye D. _____ R. _____ }

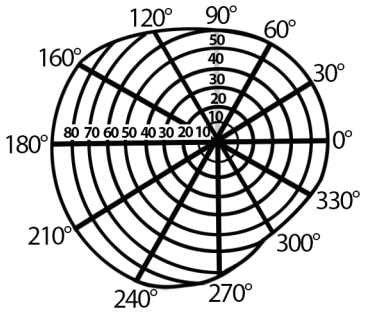
(If necessary, state vision in terms of light perception, light projection, hand movements, or ability to count fingers).

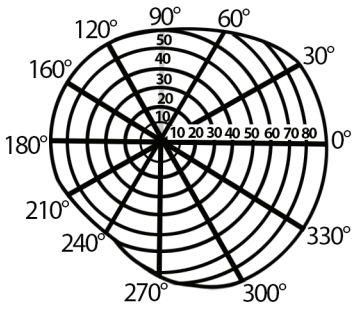
Refraction Record: Right eye (prescription) _____ Left eye (prescription) _____

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

Central scotomata may also be plotted below.

LEFT





RIGHT

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 _____