

VISION PROGRAM REFERRAL FORM  
PROVO SCHOOL DISTRICT

Student: \_\_\_\_\_ DOB: \_\_\_\_\_  
Parent Name: \_\_\_\_\_ Parent Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
School: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Date of Request: \_\_\_\_\_ Requested by: \_\_\_\_\_

Medical Diagnosis/Information: \_\_\_\_\_

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Special Education Services currently provided: \_\_\_\_\_

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Is the student new to the district? Yes            No  
If so, attach the previous IEP with the Vision Referral, and ophthalmology report.  
Is the student currently enrolled in the Provo School District? Yes            No  
Is there a "Permission to Test" on file? Yes            No

**Check any items that apply:**

Does the student wear glasses? Yes            No            Sometimes  
Does student sit in the front row? Yes            No  
Does he/she complain of not seeing? Worksheets: Yes            No  
Computer: Yes            No            White/Blackboard: Yes            No  
Did he/she pass the school nurses' eye exam? Yes            No  
Is there an ophthalmology report? Yes            No  
Is there anything else you have noticed that affects the student's performance? \_\_\_\_\_

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**Check any additional items you have observed:**

- Brings head to paper, computer, etc.
- Turns head to side to view something in his central vision
- Doesn't use eye contact
- Nystagmus—eyes shaking from side to side or up and down
- Strabismus—either eye turns in or out
- Bumps into walls or something continuously
- Over reaches or under reaches to pick something up
- Over steps or under steps on the stairs or curb consistently
- Squint eyes consistently
- Has trouble transitioning --hesitates to move from one texture to another---from carpet to floor; sidewalk to blacktop; from grass to sand, etc.