Educational Service Unit # 8

Revised: 4/28/10

School Referral for Vision Services

Please answer all questions as completely as possible. **Return this form and other documents listed on the Vision Referral Checklist to: Ruth Miller @ Educational Service Unit #8; PO Box 89; Neligh, NE 68756.**

Contact Information
Name of School _____ District # _____
Name of person making the referral _____ Phone # _____

Student Information
Student Name _____ Birth Date _____ Age _____ Grade _____ Sex ____
Parent(s)/Guardian(s) Name _____
Student lives with _☐_parent _☐_grandparent _☐_foster parent _☐_other
If the student is living with someone other than a parent, please list who has educational rights.
_____
Primary language spoken in the home _____

Reason for the referral (Describe your vision concerns for this child. Be specific)
_____
_____
_____

Health Information:
Is the student currently under the care of a physician for any condition? _____If yes, what condition? _____

Has the student ever been under the care of a physician for emotional, behavioral, seizure disorders, genetic disorders, ADHD, childhood depression, etc.? _____If yes, please describe the condition and include medical reports that are in the child's file. _____
_____

Is the student currently taking any prescribed medications or herbal remedies? _____ If yes, please list the name, the dosage, and the purpose of the medication or herbal remedy. _____
_____

Does this child wear glasses? _____ Contacts? _____
Does this child have a hearing impairment? _____

Signature of person making referral _____ Position_____
Date _____
Signature of authorized school official _____ Position_____
(administrator) Date _____