Educational Service Unit # 8

Revised: 05/2025

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: Mary Johnson, vision instructor mary.johnson@esu8ne.org - Educational Service Unit #8; PO Box 89; Neligh, NE 68756.**

Contact Information

Name of School _____ Phone # _____

Name of person making the referral _____ email _____

Student Information

Student Name _____ Birth Date _____ Age _____ Grade _____ Sex ____

Parent(s)/Guardian(s) Name _____ Phone _____

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)

_____

_____

_____

Background Information:

Is the student currently or has been under the care of a physician for any condition including seizuer disorders, genetice disorders, ADHD? _____If yes, what condition and please describe the condition and include medical reports that are in the child's file?

_____

Is the student currently receiving any other special educations services or interventions? If yes, please list.

_____

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 _____