Appendix B: Sample Assessment Forms

Sample Assessment Forms:

Form A: Parent Guardian Authorization Form
Form B: School Request for Medical Information
Form C: Sample medical form
Form D: Parent/Guardian Interview
Form E: Classroom Teacher/Related Service Provider Interview
Form F: Student Interview

The following assessment forms are provided for your use as samples/guidelines and are not intended to be exclusive of other assessment tools.

Note: In order to complete an assessment of a student with visual impairments, written consent must be obtained from the parent/guardian. Evaluation Consent Form (N1A).

School District/Agency Letterhead
Form A – SAMPLE Parent/Guardian Authorization Form

1. I hereby authorize (name of hospital, health organization, or educational provider) to disclose and/or use the following protected confidential information from the medical/educational records of the patient/student listed below. I understand that information used or disclosed pursuant to this authorization may be subject to federal or state law protecting its confidentiality.

   Address: ___________________________ Phone #: __________________

2. Patient’s/Student’s Name: ___________________________ DOB: __________________

   Address: ___________________________ Phone #: __________________

3. Please send the following information for the time period from _______ to _______

   - □ Ophthalmologic Reports
   - □ Optometric Reports
   - □ Developmental History
   - □ Individual Family Service Plan
   - □ NICU Summary
   - □ Primary Care Summary
   - □ Audiology Reports
   - □ Reports by Teachers/Therapists
   - □ IEP/504 Plan
   - □ Genetics Reports
   - □ Neurological Reports
   - □ Pediatric Reports
   - □ ENT Reports
   - □ Other: ______________________________________

5. The above information is disclosed for the following purposes:

   - □ Medical Care
   - □ Educational
   - □ Other

6. I understand that I may revoke this authorization at any time by requesting in writing the above referenced provider to do so, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

7. This authorization expires on: ___________________________

   (Insert applicable date or event)

   ___________________________ ___________________________
   Signature Date

Relationship to patient or authority to act for patient

Important: This authorization shall be deemed invalid unless all numbered entries are completed. In certain situations an additional authorization to release sensitive, legally protected information may be required.

Guidelines: For the Specialized Assessment of Students with Visual Impairments
Date: _________________________________

Dear Dr. _______________________________,

Your patient, _______________________________ DOB: ____________ has been referred for a special education evaluation. In order to provide an appropriate evaluation, we need accurate, up-to-date information on this student’s visual status. Please complete Form C accompanying this letter and return it to the address listed on the form no later than ____________________.

If you prefer to write a narrative report rather than using Form C, please make sure to include the information requested on the form. The information you are providing is a crucial first step in determining the educational needs of (student name). You are providing important information for the Team. We look forward to receiving the completed form.

A signed Parent/Guardian Authorization Form (Form A) is included with this letter.

Thank you very much for taking the time to provide this vital information about your patient.

Sincerely,

_________________________________________  ____________
Signature                               Date

_________________________________________
Title
Student Name: ___________________________ Date of Birth: ___________________________

Name of Doctor: ___________________________ Ophthalmologist ☐ Optometrist ☐

Doctor’s Address: ___________________________

Doctor’s Email: ___________________________ Phone: ___________ FAX: ___________

Date Form Sent to Doctor: ___________________________

Visual Diagnosis: ___________________________

Age of Onset: ___________ Prognosis: ___________________________

**Acuities, best corrected for near and distance.** Please indicate the type of acuity test used.

<table>
<thead>
<tr>
<th>Distance:</th>
<th>OD</th>
<th>OS</th>
<th>OU</th>
<th>Test used</th>
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<table>
<thead>
<tr>
<th>Near:</th>
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</table>

**Note:** FDB (Functions at the Definition of Blindness) may be used if no ocular pathology is diagnosed but child functions as blind.

Does the student meet this criterion? Yes ☐ No ☐

**Alternate Acuity Testing?** Yes ☐ No ☐ Please describe: ___________________________

**Glasses Prescribed?** Yes ☐ No ☐ If so, please indicate purpose(s): ___________________________

- Full-time wear ☐ Near viewing only ☐ Distance only ☐ Bifocal ☐ Protective ☐

**Prescription for Glasses:**

OD ___________________________ OS ___________________________

**Visual Field:** Describe any field constrictions or preferences. Please indicate test used, and describe testing procedure. Attach any visual field charting.
Low Vision Devices Recommended?  Yes ☐  No ☐  
If so, list non-optical and optical, power, type, and purpose.  ________________________________  

__________________________________  

Is follow-up recommended?  Yes ☐  No ☐  

Alignment/Binocularity/Motility Concerns?  Yes ☐  No ☐  
If yes, please describe  ________________________________  

__________________________________  

Eye Patching Program Recommended?  Yes ☐  No ☐  
If so, please describe:  ________________________________  

__________________________________  

Treatment Plan (i.e., medication, surgery, patching, referral for additional testing):  Yes ☐  No ☐  

__________________________________  

Other Medical Diagnoses, Relevant Medical Information, or Comments in General (i.e., other systemic conditions, medication prescribed):  ________________________________  

Is the student registered with the Massachusetts Commission for the Blind?  
Yes ☐  No ☐  

Do you have any questions or additional comments for the evaluation team?  If so, please elaborate. 

__________________________________  

__________________________________  

__________________________________  

Signature of Eye Doctor  ___________________________  Date:  ____________  

Please return this form to:  
Name/Title:  ________________________________  
Address:  ________________________________  
Phone:  ___________________________  FAX:  ___________________________  
E-mail:  ________________________________  

Guidelines: For the Specialized Assessment of Students with Visual Impairments
Guidelines: For the Specialized Assessment of Students with Visual Impairments

It is recommended that a licensed teacher of students with visual impairments conduct the interview. This interview guide should be used to elicit purposeful information from the parent or guardian in five main categories: medical background, visual functioning, social/emotional development, social/educational milestones, and general life.

Student Name: __________________________________________
Parent/Guardian Name(s): __________________________________
Date of Interview: _______ Location: ________________ Time: _______

MEDICAL BACKGROUND

1) Please tell me what you know about your child’s vision (diagnosis, acuity, fields, etc.):

2) Name of eye care professional(s):
   Date of most recent exam:

3) Describe your child’s general health:

4) Is your child taking any medications?
   [ ] Yes Name and dose: __________________________
   [ ] No

5) Has your child been diagnosed with any other medical conditions? [ ] Yes [ ] No
   If so, please describe:

VISUAL FUNCTIONING

1) What does your child understand about his/her vision? Please explain.
2) Does your child’s vision limit his/her physical movements/activities at home or at school? Please explain:

3) What responsibilities does your child have within the family? Please explain.

4) What, if any, adaptive aids or devices are used by your child to compensate for the vision loss (e.g., communication board, white cane, CCTV, Braille note-taker)?

5) Do you have any specific concerns about your child’s visual behaviors (e.g., head tilt, squinting, poking)? Please explain.

SOCIAL/EMOTIONAL DEVELOPMENT

1) What are your child’s favorite things to do when not in school?

2) What kinds of activities does your child enjoy most at home and at school (e.g., sports, games, hobbies, or clubs)? Please describe.

3) Who are your child’s favorite people (e.g., friends, teachers, family members)? Please explain.

4) How would you describe your child’s personality?

5) How would you describe your child’s greatest strengths?

6) To what extent does your child accomplish activities of daily living (e.g., self-care skills such as eating, dressing, grooming)?
SOCIAL/EDUCATIONAL MILESTONES

1) Briefly describe your child’s educational experiences (e.g., school placements, favorite teachers, most challenging activities).

2) Can you tell me about any previous assessments which your child has had (e.g., developmental/psychological /educational)?

3) What developmental and/or educational goal has your child achieved in the past that you feel has been particularly noteworthy (e.g., feeding self, learning to crawl or tie shoes, mastering Nemeth Code)?

4) What kinds of activities does your child pursue/initiate independently (e.g., brushing teeth, locating a favorite toy, reading for pleasure, pressing a switch to turn on music)?

5) What goals would you like to see your child accomplish in the next year?

6) What is your vision for your child in the next three to five years?

7) Do you have any questions or concerns that you would like to share with me or with the educational team?

Signature of interviewer: ___________________________ Date: ___________________________
Guidelines: For the Specialized Assessment of Students with Visual Impairments

School/District/Agency Letterhead

Form E – SAMPLE Interview Guide: Teacher/Related Service Provider/Staff of Students with Visual Impairments

It is recommended that a licensed teacher of students with visual impairments conduct the interview. This interview guide includes questions in three categories: communication/learning style, visual behaviors, and social/emotional behaviors. It allows the teacher to describe his/her observations about the student’s in-school interests, abilities, social relationships, and successful or unsuccessful teaching methods.

Student Name: __________________________ Date of Birth: _________ Date of Interview: _______

School: ___________________________ Grade: _______ Teacher: ___________________________

Name of Interviewer: ___________________________ Position: ___________________________

Subject Area: ___________________________

COMMUNICATION/LEARNING STYLE

1) (a) How does the student communicate (e.g., verbal, sign language, communication board)?

   (b) How do others communicate with the student?

2) How would you compare the student’s current functional level to students of the same age (below, average or above)?

3) Does this student have any known disabilities other than the vision loss? □ Yes □ No
   Please explain.

4) Do you have any other concerns about the student’s learning that you believe should be observed or evaluated further?
5) In which of the following settings does the student work best?
☐ independently, on his/her own
☐ in small cooperative workgroups
☐ in larger groups, e.g., with the entire class
☐ with one-to-one assistance

6) How does the student use unstructured time in the classroom?

7) (a) What tasks/subjects are easiest for the student, and why do you think they are easy?

(b) What tasks/subjects are most difficult for the student, and why do you think they are difficult?

8) What have you observed to be the most and least effective methods of reinforcement for this student?

VISUAL BEHAVIORS

1) (a) Check any of the following behaviors the student has demonstrated:
☐ rubbing eyes ☐ tilting head ☐ squinting ☐ holding objects/books close to face
☐ sensitivity to light ☐ visual fatigue, headaches

Please describe any other behaviors, related to a possible visual impairment, that you have observed.

(b) Are there times in the day or situations during which these behaviors are more evident? Please explain.

2) Where does the student sit in the classroom in relation to the teacher, the chalkboard, and the windows?

3) Does the student wear eyeglasses or use any magnifiers or visual aids?
4) If the student is a reader, does she/he function at or near grade level in age-appropriate reading skills? Please explain.

5) Does the student have more difficulty looking at objects/people up close or far away? Please give examples.

6) How do you think the student’s ability to take in information is limited by his/her visual functioning, if at all?

7) How do you think the student’s information output is limited by his/her visual functioning, if at all?

SOCIAL/EMOTIONAL BEHAVIORS

1) How does the student interact with peers?

2) How would you describe the student’s social strengths and/or weaknesses?

3) Does the student function better on independent tasks or in groups?

4) How would you describe the student’s confidence? Motivation?

5) Does the student make his/her needs known in socially appropriate ways?

Signature of interviewer: ___________________________ Date: _______________
Guidelines: For the Specialized Assessment of Students with Visual Impairments

It is recommended that a licensed teacher of students with visual impairments conduct the interview. This interview guide provides questions to promote dialogue with students in a non-threatening and meaningful way in order to gain information and encourage a trusting and open relationship. While some questions include possible responses and examples to help frame the interview, it is appropriate to add anecdotal comments that the student may offer beyond the original scope of the question.

Student Name: ___________________________ Date of Birth: _________ Date of Interview: _______

School: ___________________________ Grade: _____ Teacher: ___________________________

Name of Interviewer: _______________________ Position: ___________________________

Communication supports used: ___________________________

GENERAL INFORMATION

1) Tell me something about yourself (e.g., birthday, hobbies, favorite book) or your school (e.g., principal’s name, school colors, who the school is named after).

2) What do you like best about school? Why?

3) What do you like least about school? Why?

4) If you could change anything about school, what would it be? (e.g., have a shorter day, ride a different bus, do more reading or math) Why?

ACADEMICS (if age-appropriate)

1) What subjects are easiest for you? Please explain (e.g., comes naturally, good teacher/tutor, mom/dad helps).
2) What subjects are hardest for you? Please explain (e.g., print too small, class too large).

3) How do you take notes in school?

4) Do you do most of your schoolwork by yourself? If not, who helps you?

5) What is your favorite book/story that you’ve ever read/listened to, and what makes this story so special?

SOCIAL SKILLS

1) Tell me about some of your friends and classmates.

2) What do you like to do for fun?

3) What do you like to do with your free time when you’re alone?

4) What do you imagine yourself doing when you finish high school (e.g., go to college, get a job, live on your own, travel, get married)?

5) When you spend time with your sisters, brothers, cousins, or neighbors, what do you like to do (e.g., ride bikes, play games, watch TV, listen to or play music, go to the playground)?

VISUAL BEHAVIORS

1) What can you tell me about your eyes and how they work (diagnosis, acuity)?

*Guidelines: For the Specialized Assessment of Students with Visual Impairments*
2) Can you show me or describe to me any problems you experience with your eyes?
   (a) headaches ☐  (b) blurry vision ☐  (c) eye fatigue ☐  (d) eye pain ☐
   (e) tearing ☐  (f) color discrimination ☐  (g) other symptoms ☐

   For any of the items checked, the student should specify when and where these symptoms most
   often occur. The interviewer may reference the lettered items in making notes below.
   - All or some of the time?
   - At certain times of day?
   - At home or at school?
   - During certain subjects or activities?
   - Usually indoors or outdoors?
   - In bright light or low light?

3) Is it easier for you to see things up close or far away? Please give me an example.

4) Do you have any difficulty seeing any of the following?
   - letters ☐  numbers ☐  pictures ☐  colors ☐  games ☐  maps ☐
   - math problems ☐  charts and graphs ☐  Punctuation marks ☐  chalkboard ☐
   - other ☐ - explain: ________________________________

5) Do you watch television? ☐  Play computer games? ☐  Send and read e-mail? ☐

6) Where do you like to sit when reading, writing, or playing a game?
   - near a window ☐  near a lamp ☐  outside in the sun ☐
   - inside with the lights off ☐  other ☐ - explain: ________________________________

7) Do you use anything special to make your schoolwork easier?
   - eyeglasses ☐  felt tip markers ☐  dark-lined paper ☐  large print books ☐
   - magnifier ☐  extra light ☐  other ☐ - explain: ________________________________

8) If you had your choice of looking at or reading any book, which would you prefer?
   - print ☐  large print ☐  Braille ☐  audio text ☐  being read to ☐
   - CCTV ☐  other ☐ - explain: ________________________________

Signature of Interviewer: ________________________________ Date: __________

Guidelines: For the Specialized Assessment of Students with Visual Impairments