Nebraska Center for the Education of Children who are Blind or Visually Impaired

824 10th Avenue; PO Box 129
Nebraska City, NE 68410
(402) 873-5513 or (800) 826-4355
FAX (402) 873-3463
www.ncecbvi.org

SPRING LOW VISION CLINIC REGISTRATION---OUTREACH DEPARTMENT
February 23-24, 2017 (Registration Deadline is February 10, 2017)

This form must be completed by the school district's teacher of the visually impaired or staff member serving the child with a verified or suspected vision loss.

Student Name: **DOB:**

Gender: **Age:** **Grade:**

Parent/Guardian Name(s):

Parent Mailing Address (Street/PO Box, City, Zip):

Parent Email Address:

Parent Preferred Phone (+area code):

School District: **School Building:**

School Address (Street/PO Box, City, Zip):

School Contact Person: **Position:**
This person is responsible for all communication with NCECBVI and will receive any report(s) sent from NCECBVI unless noted otherwise:

Mailing Address (Street/PO Box, City, Zip):

Phone (+ area code): **Email:**

Teacher of the Visually Impaired:

Phone (+ area code): **Email:**

Billing Information

Name of Person to Send Invoice to: **Position:**

Email:

Address (street and/or box number): **City:** **Zip:**

Phone (+ area code): **Office Phone:**

Signature of Person Authorizing Services: **Date:**

Financial Agreement: The undersigned person, as a representative of the school district, authorizes services and agrees the school district is financially responsible for all charges incurred for services rendered by the Nebraska Center for the Education of Children who are Blind or Visually Impaired in accordance with the rates approved by the Nebraska Department of Education for the current school year. It is understood that all costs are considered allowable for special education reimbursement purposes.

Please indicate the specific request(s) for the Low Vision Clinic evaluation:

Ophthalmology Evaluation:
If available, students with neurological impairments please include previous MRI, CAT, or PET scans with this registration form. They will be returned the day of the exam.

Optometry/Low Vision Evaluation:
Please bring current low vision aids and eyeglasses.

The TVI serving the School District/ESU is asked to attend the Low Vision Clinic appointment with the student(s).

The documents listed below should be returned as attachments with this registration packet:

1. **Optometric Vision Report:**

   Optometrist Name:

   City: Phone (+ area code):

2. **Ophthalmological Vision Report:**

   Ophthalmologist Name:

   City: Phone (+ area code):

3. **Copy of Most Recent Functional Vision Assessment (FVA)**

4. **Pertinent Medical Report/Information**

What specific information are you hoping to gain from the low vision clinic appointment?

Appointment Information
Our preference for the day of the appointment is:

Thursday, February 23, 2017

Friday, February 24, 2017

***Efforts will be made to accommodate your request; however, your preference is not a guarantee of the date the appointment will be scheduled.*

Our preference for time of day for the appointment is:

Morning

Afternoon

***Efforts will be made to accommodate your request; however, your preference is not a guarantee of the time the appointment will be scheduled.*

The following individuals are planning to attend the appointment with the student:

Parent(s)	Name(s):
Teacher of the Visually Impaired	Name:
Special Education Teacher	Name:
Classroom Teacher	Name:
Paraeducator	Name:
Administrator	Name:
Other (specify):	Name:

Comments:

While on campus, we invite you to tour our facility to learn more about services that are available.
Are you interested in a tour of NCECBVI on the day of your appointment?

*****Following the registration deadline (February 10), NCECBVI staff will schedule appointments and contact school districts with details. If necessary, overnight and meal accommodations will be discussed at that time.***

Please note the doctor's report(s) will be mailed to the designated school contact approximately 3 weeks following the appointment.

(Permissions Found on Next Page)

Permission for Release of Confidential Information

I, , Parent/Guardian of ,

give my permission for:

To **release** the following information concerning this child:

Psychological Information

Educational Information

Medical Information

Other:

Please send this information to:
Tanya Hilligoss, Outreach Director
Mailing Address, Fax, and Email Address are provided on the first page of this form.

The purpose of this information is to facilitate appropriate educational assessments and program planning.

I understand that I may revoke this release at any time with a written notice and it is in effect for 12 months from the date of signature.

I hereby give my permission for photographic and audio-visual tapes/images to be taken of my child during services provided by NCECBVI to facilitate appropriate educational assessments and program planning.

Signature of Parent/Guardian: Date:

Please return this completed form in one of the following formats:

U. S. Mail: NCECBVI, Attention: Tanya Hilligoss, 824 10th Avenue, P.O. Box 129, Nebraska City, Nebraska, 68410

Fax: NCECBVI, 402-873-3463, Attention: Tanya Hilligoss

Email: thilligoss@esu4.net