The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Vocational and Educational Services for Individuals with Disabilities
New York State Resource Center for Visually Impaired
2A Richmond Avenue, Batavia, NY 14020
(585) 343-5384 / FAX (585) 343-0652

# 2009-10 REGISTRATION FORM FOR CHILDREN CLASSIFIED AS LEGALLY BLIND

(Central Visual Acuity of 20/200 or less in the better eye after correction or a field of vision restricted to a 20 degree arc or less)

**Name of Student** _____ **Date of Birth** _____
(Last) (First) (M.I.) Month Day Year

**Sex**: Male ☐ Female ☐ **Grade*** _____

District or Agency where individuals receive special services for the visually impaired during school hours:

Name: _____ Public ☐ Private ☐
Address: _____ Phone: ( ) _____
_____ Fax: ( ) _____
_____ E-mail: _____

District of Residence (Home District) _____

Student's **VISUAL ACUITY** based upon an existing report of an eye specialist (optometrist, oculist or ophthalmologist)

**Vision after correction*** _____ RIGHT EYE ☐ LEFT EYE ☐

Indicate the student's ***ONE*** PRIMARY AND ALL SECONDARY READING MEDIUMS in the spaces at the right using the appropriate letter:

| | | |
|---|---|---|
| VISUAL READER – uses regular OR large print . . . . . | V | Primary _____ |
| BRAILLE READER – uses braille . . . . . | B | |
| AUDITORY READER – uses reader OR recorded material . . . . . | A | 2nd _____ |
| PREREADER – readiness level OR medium undetermined . . . . . | P | |
| NONREADER – does not fall into any above category . . . . . | N | |

Primary Language of Learner: ☐ English ☐ Spanish ☐ Other

***See enclosures for appropriate coding and/or instructions**

## PERSON COMPLETING THIS FORM

Name _____ Title _____

School District _____ Phone ( ) _____

E-mail Fax ( )

**REVISED 10/09**