**Referral Form Visually Impaired Department**

**Jordan School District**

1. **Student Information**

Student Name:_____

Age:_____

School:_____

Grade Level:_____

2. **Parents Information**

Parents Name:_____

Phone number:_____

3. **Referral**

Person making the referral:_____

Title:_____

Date of referral:_____

Concern:_____
_____
_____

4. **Medical Information**

Has the student seen an eye specialist? Yes_____ No_____

Doctor's name:_____

Phone number:_____

Does the student have a current eye doctor report? Yes_____ No_____

What do you understand about the student's eye condition?_____

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Does the student wear glasses? Yes_____ No_____

**Note:**

**Please provide current eye doctor report (less than three years) with this form as well as permission to test:**

**Mail to:**

**Visually Impaired Department-Referral**

**Auxiliary Service Building (ASB)**

**7905 Redwood Rd, West Jordan 84088**

**email:**

**suzanne.miller@jordandistrict.org**