REQUEST FOR YOUTH LOW VISION SERVICES

Eligibility: Youth, age birth through 26 receiving Visually Impaired Services through the local school district may be eligible based upon one of the following criteria:

- Visual acuity of 20/70 or less in the best corrected eye
- Visual field restriction less than 20 degrees or less

_____ **Application for service:** An eye report must be included with this referral if this is the first time Youth Low Vision Services are being requested on behalf of identified student.

_____ **Referral for Bi-Annual Evaluation**

_____ **Other:** _____

Student's name: _____
Social Security Number: _____
Date of birth: _____
Address: _____
City, state, and zip code: _____
Telephone number, including area code: _____
Vision/Medical Insurance: _____
Low Vision Provider: _____
Teacher Consultant: _____ **Telephone:** _____
School District: _____

Parent/guardian signature

I am applying for Youth Low Vision services available from the Bureau of Services for Blind Persons (BSBP) on behalf of my child. In signing this referral form, I also authorize BSBP staff to share information with the referring school district and low vision practioner as necessary to provide optimal services.

Signature: _____ **Date:** _____
Print name: _____
Contact Number: _____