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

NCECBVI Vision Clinic Registration Form

February 7, 2024

Registration deadline is Friday, December 15, 2023

Return this form and other required information to Kelly Juilfs (kjuilfs@esu4.net)

Student Name: Date of Birth: Grade:

School District:

Teacher--Visually Impaired (TVI): TVI Phone (+area code):

**Please note that the TVI is expected to attend the Clinic appointment, along with the student and parent/guardian. It is expected that the TVI share the Vision Clinic appointment day, time, and additional details with the student's parent(s)/guardian.*

The following information must be attached to this registration form or sent via email (please check):

___Previous eye report(s)
___Functional Vision/Learning Media Assessment
___MDT
___IEP
___Video of the student in the learning environment (email to kjuilfs@esu4.net)

A Zoom meeting will be scheduled (approx. 30 min) with members of the student's team once all the registration paperwork is received and reviewed by our clinic specialists in an effort to gain and discuss specific information to prepare for the appointment.

Please indicate a first (1), second (2), and third (3) choice for the Zoom meeting, in order of preference.
A confirmation email will be sent to the TVI after the registration deadline that includes the selected date/time, along with the Zoom link to join the meeting. Times listed are in Central Standard Time.

Friday January 5, 2024: __7:30 a.m. __1:45 p.m. __2:15 p.m. __3:00 p.m.
Monday, January 8, 2024: __12:00 p.m. __3:00 p.m. __3:45 p.m.

School Staff to Complete:

1. **Primary Area of Concern:** Identify the instructional area or access area in which the student is having difficulty. What specifically does the student need to be able to do that is currently difficult to do independently? *(For example: The student is struggling with visually accessing materials, posters, and boards from a distance).* Please be specific.

2. **Related Service(s):** Please list any related services that the student currently receives. Additionally, please note if there are concerns in any related service areas, or that the student's team would like additional consultation or support from (e.g., physical therapy, occupational therapy, orientation and mobility, speech-language therapy, low vision)?

3. **Name the environment(s) where the student is experiencing the area of concern.** *(For example: The student struggles with seeing the markerboard from his desk in the classroom).* Please be specific.

4. **Are specific accommodations, modifications, and/or assistive technology currently in place for the student in this area of concern?** *(For example, The student has been using a monocular to view boards, etc., at a distance for the past year).* If yes, please specify and *include how long they have been in place.*

5. **What is a specific interest(s) of the student that may be beneficial in helping the Clinic team prepare materials for the appointment?** *(For example: dogs, weather, Huskers, specific book/TV program/singer/sport, etc).*

6. *Optional* If there is a secondary area of concern for the student, please specify the information below, including issues and information with: environment(s), daily living tasks, mobility issues, communication difficulties, programming, and/or any current services, interventions, accommodations, modifications, and/or assistive technology in place for that concern.

7. Other information that is important to note about the student: ----------
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Person to Receive Invoice: Position:

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

Email: Phone (+area code):

Signature of District Representative: Date:

Financial agreement: As a representative of the school district, this person 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.

Parent/Guardian to Complete:

Prior to, and during the Vision Clinic, NCECBVI is requesting parental consent to share records, videos, photographs, and provided information about the student with the optometrist and Vision Clinic specialists:

As the parent/guardian of the above named student, I give permission to release the above listed information with the optometrist and Vision Clinic specialists prior to, during, and following the Vision Clinic to be held at NCECBVI in Nebraska City. I understand I may revoke this release at any time with a written notice.

Parent/Guardian Signature: Date:

As the parent/guardian of the above named student, I hereby authorize the Vision Clinic specialists and the optometrist to allow the use of pictures, videos, and/or voice reproductions or other identifiable information of my child for the purpose of educational projects, data collection/assessment purposes, public relations, school publicity, and other beneficial endeavors as long as such usage is not for the financial or personal benefit to any individual and/or groups or private company. This includes posting of photos on the NCECBVI Facebook page. I understand I may revoke this release at any time with a written notice.

Parent/Guardian Signature: Date:

Contact Information:

Parent/Guardian Name(s):

Mailing Address (Street/P.O. Box):

City:

Zip:

Preferred Email Address:

Preferred Phone (incl. area code):

Parent/Guardian Signature: Date: