Verification of Disability in the Education Adjustment Program Category of Vision Impairment

Members of the non state school team complete this form collaboratively, ensuring that relevant personnel have been involved in the data gathering and decisions relating to the impairment and activity limitations and participation restrictions for this student.

This verification form is used for verification requests for students enrolled in non state schools only.
This form consists of the following sections which **must** be completed:

- **PART A** Student Details
- **PART B** Evidence Supporting Verification of Disability
- **PART C** Principal Request for Verification of Disability

Please attach signed EAP consent form and supporting documentation (and medical reports) as appropriate.

Email this completed verification request to: **vi.eap@qed.qld.gov.au**
Subject line: EAP Verification Request - Student Name

PART A: Student Details

Last Name | **Date of Birth**
First Name | **Sex**
AIMS ID | **EQ ID** | **Year Level**
Non State School | **Phone**
School Address
School contact person | **Position**
Email Address | **Phone**

Existing Categories:

☐ Nil ☐ ASD ☐ HI ☐ ID ☐ PI ☐ SLI ☐ VI

This verification request is for:

- ◯ Initial Verification (i.e. no previous verifications)
- ◯ Review of an existing verification
- ◯ Review of an expired verification (more than 2 years past verification review date on AIMS)
- ◯ Adding a new category to an existing verification
- ◯ Removal from an existing category.

EAP Office Use Only:

Date Received:	Assigned:	AIMS:	Database:	Archive:

Part B: Evidence Supporting Verification of Disability in the Education Adjustment Program Category of Vision Impairment

Criterion 1:

Student must be diagnosed with a vision impairment involving

- ocular components and/or
- the visual cortex and/or
- the functions and structures adjoining the eye

with

- a visual acuity of less than or equal to 6/18, according to the Snellen Chart, best corrected and/or
- a visual field loss and/or
- significant fluctuating visual access

MEDICAL SPECIALIST REPORT

This form is to be filled in by an ophthalmologist or in some cases of Cerebral (Cortical) Vision Impairment, by a paediatrician or neurologist.

Student Last Name		**Student First Name**	
School		**Date of Birth**	
Sex		**Year Level**	

I. CAUSE OF VISION IMPAIRMENT

A. Primary Ocular Condition:

B. Secondary Ocular Condition/s:

C. Is the condition: ◯ genetic ◯ acquired ◯ unknown

II. MEASUREMENTS

A. VISUAL ACUITY

Distance Vision (include at what distance acuity was measured)

	Without Correction	With Best Correction	With Low Vision Aid
Right Eye (O.D)			
Left Eye (O.S)			
Both (O.U)			

Glasses Prescription: Right Eye Left Eye

Near Vision (include at what distance acuity was measured)

	Without Correction	With Best Correction	With Low Vision Aid
Right Eye (O.D)			
Left Eye (O.S)			
Both (O.U)			

B. FIELD OF VISION

Is there a limitation? ◯ Yes ◯ No

Attach perimetry results, if available.

C. COLOUR

Is there impaired colour perception? ◯ Yes ◯ No

Test Used:

III. OTHER VISUAL CONSIDERATIONS (e.g. Glare sensitivity)

IV. PROGNOSIS AND RECOMMENDATIONS

A. Is the student's vision impairment considered to be: ◯ stable ◯ deteriorating ◯ better than average ◯ uncertain

B. What treatment is recommended, if any?

C. When is re-examination recommended?

D. Lighting requirements: ◯ average ◯ better than average ◯ less than average

E. Physical activity: ◯ unrestricted ◯ restricted as follows:

Name of Specialist

Position: ☐ Ophthalmologist ☐ Paediatrician ☐ Neurologist

Address

Phone **Fax**

Email

Signature **Date**

Criterion 2:

Documented evidence of significant educational impact (activity limitations or participation restrictions) resulting from the vision impairment in one or more of the following focus areas

- **curriculum**
- **disability specific curriculum**
- **learning environment.**

This section is to be completed by the **student's teacher** in collaboration with the school team, including a teacher with training and experience in vision impairment. Evidence needs to be provided about how the vision impairment impacts on the student and their access and participation in all aspects of school life in and out of the classroom.

Evidence of the educational impact of the vision impairment

The *Prompts for VI Criterion 2 Form* can be used as a *guide* for the completion of this section

https://education.qld.gov.au/student/Documents/prompts-vi.pdf

CURRICULUM

achieved curriculum - knowledge, functioning and understanding of the world - teaching strategies - resources - assessment/reporting

Describe the **student's functioning** related to the **vision impairment:**

Describe the **associated education adjustments:**

COMMUNICATION

receptive - expressive - pragmatics (language use) - speech

Describe the **student's functioning** related to the **vision impairment:**

Describe the **associated education adjustments:**

SOCIAL PARTICIPATION / EMOTIONAL WELLBEING

social/interaction skills - self-management strategies

Describe the **student's functioning** related to the **vision impairment:**

Describe the **associated education adjustments:**

LEARNING ENVIRONMENT / ACCESS

classroom and non-classroom environment - organisational skills - mobility - access

Describe the **student's functioning** related to the **vision impairment:**

Describe the **associated education adjustments:**

HEALTH AND PERSONAL CARE, SAFETY CARE
health management - risk management - personal care skills

Describe the **student's functioning** related to the **vision impairment:**

Describe the **associated education adjustments:**

Criterion 2 information completed by:

Name (Student's Teacher)

Signature

Date

Phone

Email

Other Persons involved: (including student and/or parent)

Name **Email**
Role

Name **Email**
Role

Name **Email**
Role

Name **Email**
Role

Name **Email**
Role

Name **Email**
Role

Part C: Principal Request for Verification of Disability in the Education Adjustment Program Category of Vision Impairment

Verification of disability in the EAP category of Vision Impairment according to departmental criteria is requested for the following student according to the details outlined in PART A and PART B of this report and the related attachments:

Student Name

School **Date of Birth**

In making this request I have ensured that:

- the student is enrolled and attending the school
- a completed *EAP Consent Form* is kept in the student's school file and a copy attached to this verification request
- discussions have been held with the parent and/or student regarding this verification and agreement to proceed has been reached
- appropriate personnel have been involved in data gathering and reporting
- processes are in place to support this student within the school
- all documents for verification are complete
- the original EAP Verification Form is kept in the student's school file
- copies of relevant documents will be sent to the EAP Verification Team
- student details are registered on the Adjustment Information Management System (AIMS)

Principal Name

Email

Principal Signature **Date**