RELEASE OF INFORMATION
FOR VERIFICATION OF VISUAL IMPAIRMENTS

The student completes the following:

I, _____, herby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for academic accommodations.

Student's Signature _____ Phone: _____

Student's Z# _____ Date of Birth: _____

☐ Please return paperwork to client/student.

☐ Please return the completed information to the campus checked below:

☐ Florida Atlantic University
Student Accessibility Services
777 Glades Road, SU 133
Boca Raton, FL 33431
tel: 561.297.3880 fax: 561.297.2184

☐ Florida Atlantic University
Student Accessibility Services
3200 College Avenue, LA 131
Davie, FL 33314
tel: 954.236.1222 fax: 954.236.1123

☐ Florida Atlantic University
Student Accessibility Services
5353 Parkside Drive, SR 111F
Jupiter, FL 33458
tel: 561.799.8585 fax: 561.799.8819

VERIFICATION OF VISUAL IMPAIRMENT

(To be completed by qualified diagnostician)

Patient's Name: _____ Date of Most Recent Examination: _____

Your input will assist us in determining what accommodations are appropriate to provide the student equal access to programs, services, and learning.

1. Diagnosis: Right eye _____ Left eye _____
2. Etiology: Right eye _____ Left eye _____
3. Prognosis: Permanent ☐ Temporary ☐ How long? _____
4. Please complete the chart below:

Visual Acuity	RE Distance	RE Nearness	LE Distance	LE Nearness
Without Correction				
With Best Correction				

5. Are there any abnormalities in the field of vision? Right eye _____ Left eye _____

   If yes, what is the widest diameter in degrees in the remaining field of vision?
   Right eye _____ Left eye _____

6. Is there any medication that may affect attention, concentration, or any other facet of learning or living environment? Yes ☐ No ☐

   Medication: _____ Side Effects: _____

7. Describe in detail the student's functional limitations associated with this diagnosis. How might this disability impact the student academically?

_____

_____

_____

8. Are there any specific academic accommodations you would recommend for this student?

_____

_____

Please attach any additional documentation which you feel may help us determine the most appropriate assistance for this student.

CLINICAN'S NAME (Printed) _____

CLINICIAN'S SIGNATURE_____ DATE_____

CREDENTIALS_____

LICENSE/CERT. # _____ STATE_____

Please attach your business card.