Bucks County Community College

Verification Form

Vision Impairments

Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Vision Impairments to obtain current information from a qualified practitioner (e.g., optometrist, ophthalmologist) regarding a student's vision impairment and its impact on the student and his or her need for accommodations. This Verification Form may supplement information that is provided in other reports, including medical reports or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College's TAO guidelines for Vision Impairments conditions. **The person completing this form may not be a relative of the student or hold power of attorney over the student.**

A summary of the guideline criteria for documenting hearing impairments can be found at the following web site: http://www.bucks.edu/student/accessibility/student-info/. A summary of the guideline criteria for documenting Vision Impairments is as follows:

1. Evidence of current vision impairment
2. Functional impairment affecting an important life skill, including academic functioning
3. History of use of visual aids or assistive technology related to vision impairment
4. Summary and recommendations

Section I: Student Information (Please type information or print legibly)

Student Name: _____
Last First Middle

Student ID: _____ **Date of Birth:** _____

Cell Phone: _____ **Home Phone:** _____

Bucks Email: _____ **Home Email:** _____

Permanent Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Local Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Section II: Provider Section (Please type information or print legibly)

A. Contact with the Student:

Date of initial contact with the student: _____

Date of last contact with the student: _____

Frequency of appointments with student (e.g., once a week, once a month)**:** _____

B. Diagnosis Information:

1. **What is the student's diagnosis?**

Newtown Campus • Student Services Center • Rollins Building • 275 Swamp Road • Newtown • PA • 18940
(215) 968-8182 • (215) 968-8033 fax • accessibility@bucks.edu • http://www.bucks.edu/student/accessibility/

2. When was the student diagnosed with the condition?

Month _____ Year _____

3. What is the severity of the impairment? ☐ Mild ☐ Moderate ☐ Severe

a. Explain the severity checked above:

4. What is the expected duration of the impairment?

Short-term (<6 months):	☐	Long-term (>6 months-1 year):	☐
Episodic:	☐	Chronic (>1 year with frequent recurrence):	☐

c. Explain the duration checked above:

5. Current Symptoms:

a. What is the student's current best-corrected visual acuity and visual field in each eye (please explain in detail)?

Visual Acuity (e.g., 20/XX)		Visual Field (e.g., XX degrees)	
Distance	Near	Central	Peripheral

b. Is the vision loss expected to remain stable or is it expected to decline? If it is expected to decline, please describe the expected progression of the vision loss.

c. Describe the proficiency of orientation and mobility of the student for independent travel (e.g., proficient in cane usage; uses a guide animal; has usable vision; uses GPS technology or other technologies; needs additional O & M training).

d. Is there clear evidence that the symptoms associated with the vision impairment are interfering with or reducing the quality of at least one of the following, including academic functioning?

Environmental Functioning:	
School functioning:	
Social functioning:	
Work functioning:	
Language functioning:	

C. Student's History:

1. **Please include any historical information relevant to the student's vision impairment and associated functioning** (e.g., developmental, familial, medical, pharmacological, psychological, and psychosocial)**.**

2. **Assistive Technology (AT):**
   a. Are glasses, contacts, or other visual aids prescribed to assist the student's visual acuity? If so, what is the visual acuity with the glasses, contacts, or visual aids?

   b. What does the student use to access print (e.g., size of enlarged print; Braille; text reader; screen reader)?

   c. If the student currently uses assistive or adaptive technologies to facilitate visual performance, please list specifics related to the brand, model number, and proficiency of and setting for use (e.g., educational, home, work).

3. **ICD-10-CM Diagnosis Codes:** Please include all pertinent diagnoses or rule-out diagnoses using ICD-10-CM codes.

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D. Medications:

1. Is the student currently taking medication(s) for any symptoms related to the diagnosis? ☐ Yes ☐ NO

2. If yes, please provide information below for each medication the student is currently prescribed:

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

D. Functional Limitations and Recommended Accommodations:

1. Please list the student's current symptoms associated with the vision impairment and then indicate what reasonable academic accommodations would mitigate the symptom listed.

2. **Sample:** Due to vision impairment, the student cannot read written information.

Symptom: (Example)
Visual acuity extremely low
Recommended Reasonable Accommodation(s):
Reader for tests or use of screen reading program (i.e., JAWS)

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
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Symptom:
Recommended Reasonable Accommodation(s):

Section III: Provider's Certifying Professional Information:

(Please type information or print legibly)

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (i.e., optometrist, ophthalmologist). The provider signing this form must be the same person answering the above questions.

Provider's Name: _____
Last First Middle

Credentials: _____

License Number: _____ **State of Licenser:** _____

Phone Number: _____ **Email:** _____

Practice Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

May this completed Verification Form be released to the student? ☐ **Yes** ☐ **NO**

Provider Signature: _____ **Date:** _____

Section IV: Submitting this Form

This form should be returned to the Accessibility Office (TAO) at Bucks County Community College where the student is enrolled. All forms need to be submitted at the Newtown campus. Please see the following methods of submission of this form:

Email: accessibility@bucks.edu

Fax: (215) 968-8033

USPS: Bucks County Community College
Attention: The Accessibility Office
275 Swamp Road
Newtown, Pennsylvania 18940

Physical Drop Off: Newtown Campus
Rollins Center • Student Services Office • Room 001

Information regarding the Accessibility Office (TAO) at Bucks County Community College can be found at http://www.bucks.edu/student/accessibility/. Please visit our website for the latest information and updates as they are made available. If you have any questions, please feel free to call us (215) 968-8182.