South East SELPA

CHECKLIST FOR
A REFERRAL TO THE PROGRAM
FOR STUDENTS WITH VISUAL IMPAIRMENTS

To refer a student for evaluation for vision services, please follow these steps:

- ☐ Complete the "Referral for Vision Services" form
- ☐ Complete the "Authorization for Release of Medical/Educational Information for Students"
- ☐ Have the student's parents complete and sign that form with the following information:
  - Ophthalmologist's name, address and telephone number
  - Authorization for the ophthalmologist to release information to:

    Vision Specialist
    South East SELPA Program for Students with Visual Impairments
    3434 Marten Avenue, San Jose, CA 95148
    Fax: 408-532-9311
- ☐ Attach any available medical reports
- ☐ Attach the eye report, of an exam completed within the past year, by a licensed eye specialist—either an ophthalmologist or optometrist
- ☐ Attach any available IEPs
- ☐ Send all information to:

  Michele Villarreal
  Program Administrator
  South East SELPA Program for Students with Visual Impairments
  3434 Marten Avenue
  San Jose, CA 95148
  Fax: 408-532-9311
  Email: mvillarreal@mpesd.org

After reviewing the information, the vision specialist will contact the referring party. The vision specialist will verify the student has a visual impairment. To be eligible for special education a pupil must have a visual impairment that, even with best correction, adversely affects his or her educational performance.

South East SELPA
Program for Students with Visual Impairments
REFERRAL FOR VISION SERVICES

Child's Name:
Date of Birth:
Age:
Grade:
Address:
Father/Guardian:
His Phone Numbers:
His Email:
Mother/Guardian:
Her Phone Numbers:
Her Email:

Teacher:
Teacher's email:
District:
School:
Address:
Telephone:
Fax:

Student's Visual Acuity with Best Correction:
Does the Student Wear Prescription Glasses or Contacts?
Student's Ophthalmologist:
Address:
Telephone:
Fax:

Please describe:

1. **The reason for referral, including specific observations:**

2. **Student's educational performance:**

3. **Student's classroom behavior:**

4. **Student's strengths:**

Referring Party: _____

Name **Title** **Signature** **Date**

Principal/Prog Sp/Dir: _____

Name **Title** **Signature** **Date**

SANTA CLARA COUNTY

SPECIAL EDUCATION LOCAL PLAN AREA
HIPAA PRIVACY AUTHORIZATION FOR RELEASE OF MEDICAL/EDUCATIONAL INFORMATION FOR STUDENTS

Student Name _____

Medical Record Number/ID Number _____ DOB ____/____/____

Address _____ City _____

State _____ Zip _____ Telephone _____

PERSON/ORGANIZATION INFORMATION WILL BE REQUESTED FROM:	PERSON/ORGANIZATION INFORMATION WILL BE SENT AND/OR DISCLOSED TO:
District:	District:
Name:	Name:
Address:	Address:
City/State/Zip	City/State/Zip:
Telephone: Fax:	Telephone: Fax:

Check box to specify information requested and to be released: (Parent/Guardian to initial)

_____ ☐ Psycho-educational evaluations/records
_____ ☐ Speech & Language records
_____ ☐ Mental health records
_____ ☐ Cumulative/Educational File
_____ ☐ Medical records pertaining to _____
_____ ☐ Other records (Specify) _____

_____ ☐ Health & Developmental
_____ ☐ Vision evaluations
_____ ☐ Hearing/Audiological evaluation
_____ ☐ Birth records

DESCRIPTION OF EACH PURPOSE FOR THE USE OF RELEASE OF THE INFORMATION

The person and/or organization who receives the information authorized on this form may only use it for the following educational purposes:

☐ Eligibility ☐ Educational Planning ☐ Health Services ☐ Transition

☐ Other: Specify _____

SANTA CLARA COUNTY

SPECIAL EDUCATION LOCAL PLAN AREA
HIPAA PRIVACY AUTHORIZATION FOR
RELEASE OF MEDICAL/EDUCATIONAL INFORMATION FOR STUDENTS

This authorization shall become effective immediately and shall remain in effect for **one year from the date of signature** unless a different date is specified here: _____ (date)

I understand that the District and/or Representative shall have full authority to request and receive information in regards to my child as stated above and within the effective timeline. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the school district representative requesting the information. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

I understand that health information used or disclosed pertaining to this authorization may be subject to re-disclosure by the receiving agency and that the information requested may no longer be protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure medical treatment, except under specific circumstance in the case of the request for physician orders, in accordance with *Education Code Section 49423.5* to provide specialized physical health care services and/or care to students with health conditions (for example: asthma, diabetes, epi-pen, gastrostomy feeding, medications, etc.) during school hours.

I consent to the release of the information indicated above and acknowledge that I have received a copy of this release; **A copy of this authorization is considered valid.**

_____ _____

Parent* Signature ***Date***

* *"Parent"* may refer to any person having legal custody of the child (eg:: biological, adoptive, or foster parents); any adult student without a guardian or conservator; a person acting as the child's parent if neither the parent nor guardian can be notified of the educational actions under consideration; or an appointed surrogate parent. *"Parent"* does not include a nonpublic, nonsectarian school or agency under contract with LEA. [EdCode 56028]