

Family Member Information Form:

Note: This transmission is intended only for the use of the person or office to whom it is addressed and may contain confidential information that is privileged, confidential or protected by law.

Your Name : _____

Spouses Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # _____ email: _____

I am a Parent of a child with a visual impairment: Yes ___ No ___

I am a Professional: Yes ___ No ___

I would like to be a part of VAAPVI's online data base of parents, to connect with other parents. (The database will only share your first name only, email address, and child's diagnosis (not child's name) and only other parent members will have access via log in that is password secured) Yes ___ NO ___

I would like to be a part of VAAPVI's statewide listserv for parents and professionals raising/working with children who have visual impairments?

Yes ___ No ___

Child's Name: _____

Child's DOB: _____

Grade level: _____

School attended: _____

Eye Condition: _____

Child's functional vision: Totally blind ___ Light perception only ___ Low vision ___

Age that vision loss occurred: _____

Please elaborate on vision: _____

Other diagnosis: _____

Reading/writing medium: Braille ___ Large Print ___

Circle services currently received IN the school system and frequency:

OT _ Freq. ___ PT _ Freq. ___ ST _ Freq. ___ O&M _ Freq. ___ TVI _ Freq. ___

What kind of technology/assistance used in the school related to disability: _____
