State of Illinois
Department of Human Services

OPENING DOORS MEDICAL INFORMATION - ILLINOIS SCHOOL FOR THE VISUALLY IMPAIRED

Child's Last Name: ______________ First: ______________ Middle: ______________

Date of Birth: ______________ ☐ Male ☐ Female

Ophthalmologist: ______________ Phone: ______________

Medical Doctor: ______________ Phone: ______________

Age of vision loss: ☐ Birth ☐ Other ______________ (list)

Specific Eye Condition - Cause of vision loss: ______________

Visual Acuity RIGHT eye ______ / ______ Visual Acuity FEFT eye ______ / ______

☐ Light Perception Only ☐ No Light Perception ☐ Unknown

Does your child have other health problems? ☐ Yes ☐ No If yes, please explain: ______________

Known Allergies: ☐ Drugs, please list: ______________

☐ Foods, please list: ______________

Health History: Check all that apply: ☐ Anemia ☐ Asthma ☐ Bleeding/Clotting Disorder

☐ Diabetes ☐ Frequent Ear Infections ☐ Heart Defect ☐ Hypertension ☐ Shunt ☐ Feeding Tube

☐ Sickle Cell Anemia ☐ Hepatitis B ☐ HIV ☐ MRSA ☐ Other ______________

☐ Convulsions/Seizures, severity/type: ______________ ☐ slow recovery/ ☐ quick recovery

Date of last seizure: ______________

What triggers seizures? (List): ______________ ☐ Unknown

Special diet: ______________

Physical restrictions: ______________

Medical equipment used by infant: ______________

Mobility: ☐ walks ☐ crawls ☐ wheelchair ☐ walker ☐ uses cane ☐ pre-cane

☐ other ______________

Medication - Does your child take medication ☐ Yes ☐ No

Drug Name	Dose	Time Given	Reason

VERY IMPORTANT - Briefly describe any pre-school or educational services the child is currently receiving. **Provide Reports - Required e.g. Eye Doctor Report, Functional Vision Report, OT, PT, Speech, Nutritional, etc.** ______________

Siblings Attending Program: Name ______________ Age ______

List medical issues and allergies: ______________