

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
 Office of Special Education
 New York State Resource Center for Visually Impaired
 2A Richmond Avenue, Batavia, NY 14020
 PHONE (585) 343-5384 / FAX (585) 343-0652

2015-16 REGISTRATION FORM FOR CHILDREN CLASSIFIED AS LEGALLY BLIND

Name of Student _____ **Date of Birth** _____
 (Last) (First) (M.I.) Month Day Year

Sex: Male Female * **Grade** _____

District or Agency where the student receives special services for the visually impaired during school hours:

Name: _____ Public Private
 Address: _____ Phone: () _____
 _____ Fax: () _____
 _____ E-mail: _____
 (This will be the agency listed for the student in the database)

* **Level of visual functionality code:** FDB MDB

Primary Language of Learner: English Spanish Other _____

Indicate the student's ONE PRIMARY READING MEDIUM by indicating "1" AND ALL SECONDARY READING MEDIUMS by indicating "2" in the boxes below.

	VISUAL - Students use print to some extent
	BRaille - Students use braille to some extent
	AUDITORY - Students use a reader or auditory materials to some extent
	NOT APPLICABLE – Nonreaders, pre-readers or students with no additional reading media

***See enclosures for appropriate coding and/or instructions**

PERSON COMPLETING THIS FORM

Name _____ Title _____
 School District _____ Phone () _____
 E-mail _____