CENTER FOR THE VISUALLY IMPAIRED

BEGIN

Family Information Form
Center for the Visually Impaired
BEGIN Program

Please complete this form before your intake appointment.

Date of Intake Appointment: _____
Child's Name: _____ Date of Birth: _____
Parent Name(s): _____
Address: _____
County: _____
Home Phone Number: _____ Work Phone Number: _____
Cell Phone Number: _____ Fax Number: _____
Email Address(es): _____

Emergency Contact Information:
Name: _____
Relationship to BEGIN Child: _____
Phone Number(s): _____

VISUAL DIAGNOSIS

Visual Diagnosis: _____
Ophthalmologist: _____
Most Recent Appointment Date: _____
Ophthalmologist report/letter enclosed: Yes ☐ No ☐
(BEGIN must have an ophthalmologist's report before the eligibility assessment.)

Has your child had any **eye surgeries**? Yes ☐ No ☐

Type of Eye Surgery	Date	Hospital	Surgeon

Are any eye surgeries planned for the future?
_____
_____

BIRTH HISTORY

Length of pregnancy: _____ weeks
Birth Hospital: _____
Type of delivery: vaginal ☐ caesarian ☐ (reason? _____)
Baby's Birth Weight: _____ Length: _____
This baby is the _____(first, second, third, etc.) child for our family.
Complications during Pregnancy:

_____

_____

Complications at Birth:

_____

_____

Was baby transferred to another hospital at birth? Yes ☐ No ☐
If so, which hospital? _____
Feeding method: breast ☐ bottle ☐ feeding tube ☐ (how long? _____)
Age baby came home after birth: _____
Please tell about your child's general health since birth:

_____

_____

ADDITIONAL SERVICES

Pediatrician: _____ Phone Number: _____

Specialist Name	Specialty	Phone Number

Any surgeries **other than** eye surgeries? _____
Does your child have seizure disorder (epilepsy)? Yes ☐ No ☐
If yes, please describe your child's seizures: _____
Does your child have any severe allergies? Yes ☐ No ☐
If yes, please describe the allergy: _____
Does your child take any medications regularly? Yes ☐ No ☐

Medication	Purpose

Does your child have any therapists or teachers? Yes ☐ No ☐

Type of Therapy/Training	Name of Therapist	Location	Schedule

Does your child receive vision services from Georgia PINES? Yes ☐ No ☐
Is your child enrolled in Georgia's Babies Can't Wait? Yes ☐ No ☐
If yes, Service Coordinator/County _____

FAMILY DATA

How many people live in your household? _____

Names and birth dates of family members in your household:

Name	Birth Date	Relationship to Child

Mother's Full Name (including maiden name): _____

Mother's Occupation and Employer: _____

History of blindness or severe visual impairment in Mother's family:

_____

Father's Full Name: _____

Father's Occupation and Employer: _____

History of blindness or severe visual impairment in Father's family:

_____

Child's Daycare Provider: _____

STATISTICAL INFORMATION

Total Family Income: _____

Source of Income: _____

Would you agree to participate completely anonymously in a national survey of statistical information about children with visual impairments?

Yes ☐ No ☐

Is there any additional information that would be helpful for us to know? (Allergies, special health needs, etc.):

_____

_____

Parent/Guardian Signature and date:

_____

Please fax or mail this form to:
BEGIN Program
Center for the Visually Impaired
739 West Peachtree St NW
Atlanta, GA 30308
Fax: 404.602.4332

Authorization to Release Information

Child's Name _____ **Date of Birth** _____

Eye Doctor and Location of Office

Doctor Name | Office & Location

Teacher of the Visually Impaired

Teacher Name | Email | Phone

Georgia PINES

Name | Email | Phone

Babies Can't Wait

Name | Email | Phone

I hereby agree and consent for any agency that has information of a medical, social, educational or psychological nature concerning my child's condition to release this information to the Center for the Visually Impaired (CVI). I also agree and consent for CVI to, in turn, release information concerning my child that is of a medical, social, educational and/or psychological nature as needed by other cooperating agencies. Material released may or may not contain information related to infectious disease status. All information will be used only by professional persons for the purpose of aiding my child's education.

I give my permission for the BEGIN program of the Center for the Visually Impaired to assess my child for program eligibility using assessment instruments appropriate for a child with visual impairment.

Print Parent/Guardian Name _____ **Date** _____

Parent/Guardian Signature _____

Witness _____

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Center for the Visually Impaired
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