

# REGISTRATION OF STUDENT WHO IS BLIND/VISUALLY IMPAIRED

Colorado Department of Education (CDE)  
& Colorado Instructional Materials Center (CIMC)

**COUNT 1-STATEWIDE B/VI COUNT:** All students birth – 21 receiving vision services

SRS ACCT.  (CIMC USE)	1. STUDENT NAME – LAST, FIRST  2. SASID # (10 DIGIT)	AU CODE  (CIMC USE)
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3. DATE OF BIRTH:

4. DISTRICT OF RESIDENCE (\*may be different than District student is attending):

5. DISTRICT OF ATTENDANCE:

6. CURRENT GRADE LEVEL:

7. PRIMARY LANGUAGE OF INSTRUCTIONAL MATERIALS:

8. PRIMARY CURRENT READING MEDIA:

9. PROJECTED READING MEDIA:

10. REGISTRATION DATE:

11. PRIMARY DISABILITY:

SECONDARY DISABILITY:

12. VISION ACUITY WITH CORRECTION:

RIGHT EYE (OD)

LEFT EYE (OS)

PERIPHERAL FIELD 20° OR LESS? YES  NO

13. DIAGNOSIS:

14. IS THIS STUDENT REGISTERED IN COLORADO DEAFBLIND CENSUS? YES  NO

15. TACTILE LEARNER: YES  NO  BRAILLE LEARNER: YES  NO

BRAILLE USER: YES  NO

16. STATE ASSESSMENT: General CMAS/PARCC  Alternate CoALT/DLM  N/A

17. PLEASE CHECK THE PLAN THAT THIS STUDENT IS ON:

IEP  504 PLAN  IFSP  ISP  NO FORMAL PLAN

18. AU RESPONSIBLE FOR STUDENT ASSESSMENT FEE:

ADDITIONAL INFORMATION:

**COUNT 2-FEDERAL QUOTA COUNT:** Students who meet Federal eligibility requirements of Legal Blindness (MDB or FDB)

1. IS THIS STUDENT TO BE INCLUDED ON THE FEDERAL QUOTA COUNT? YES  NO

2. IF YES, DOES YOUR DISTRICT HAVE SUPPORTING EYE HEALTH DOCUMENTATION ON FILE?

YES  dated: \_\_\_\_\_ (Please Attach Copy of Doctor's Report) NO

SIGNATURE OF TVI COMPLETING THIS FORM:

\_\_\_\_\_  
DATE: \_\_\_\_\_  
PRINTED NAME: \_\_\_\_\_

SIGNATURE OF SPECIAL EDUCATION DIRECTOR:  
\_\_\_\_\_  
DATE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_  
ADMINISTRATIVE UNIT/AGENCY: \_\_\_\_\_  
AU ADDRESS: \_\_\_\_\_  
PHONE: \_\_\_\_\_



COLORADO  
Department of Education



PLEASE RETURN THIS FORM TO COLORADO INSTRUCTIONAL MATERIALS CENTER  
1015 EAST HIGH STREET  
COLORADO SPRINGS, CO 80903  
email: cimregistrations@cldb.org