



# Montana Association for the Blind

1802 W. Park, Anaconda, MT 59711  
406-442-9411

## 2024 SUMMER ORIENTATION PROGRAM for the Blind and Partially Sighted Sponsored by the Montana Association for the Blind, Inc.

Mail completed form to:

MAB

1802 W. Park

Anaconda, MT 59711

Or email to: [mabadmin@mabsop.org](mailto:mabadmin@mabsop.org)

Part 3 – Visual Examination Report – To be completed by your Eye Care  
Professional

**PLEASE TYPE OR PRINT CLEARLY**

If this form is not Accessible: [Click Here](#)

Name:

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### **CLIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

My medical information may be released to the Montana Association for the  
Blind's 2024 Summer Orientation Program staff, nurses, and director.

Client Signature:

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Date Signed:

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**PLEASE TYPE OR PRINT CLEARLY**

**Date of Exam**

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**Cause of Visual Impairment**

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<b>Visual Acuity</b>	<b>Distance</b>	<b>Near</b>
<b>Right: w/o correct w/correct</b>	<b>w/o correct w/correct</b>	<b>w/o correct w/correct</b>
<b>Left: w/o correct w/correct</b>	<b>w/o correct w/correct</b>	<b>w/o correct w/correct</b>

**Is the patient considered legally blind? Yes No**

**Comments and list any medications necessary:**

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**The patient will be attending a month-long, independence training program. Classes will run from 8am to 4pm. There will be some walking and standing involved. We will have a nurse on duty part-time. Are there any other physical concerns we should be aware of?**

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**Signature of examining physician:**

**Date:** \_\_\_\_\_

**Print or type name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**If you, as the student's doctor have any concerns about or program, please contact us.**