





**Referral to the Blind Children’s Vocational**

**Discovery and Development Program**

***Name of child:***

|  |  |
| --- | --- |
| Date of Birth: |  |
| SSN: |  |
| Name of parent: |  |
| Address: |  |
| City/Zip: |  |
| Phone: |  |
| Email: |  |
| Race/Ethnicity: |  |
| Currently enrolled/Grade? |  |
| School Name |  |
| How may we help you? | Referred by VI Teacher:  Other: |

|  |
| --- |
| **Visual Impairment:** |
| **Last FVLMA:** |
| **Doctors:** |
|  |
|  |
| **Other medical issues:** |
|  |
|  |
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| --- | --- |
| **Referred by:** | **Date:** |
| **Address:** | |
| **Phone:** | |
| **Please email referral along with current eye report and IEP (ARD) to:** [**BlindChildrensProgram@hhs.texas.gov**](mailto:BlindChildrensProgram@hhs.texas.gov) | |

**P.O. Box 13247 Austin, Texas 78711-3247 512-424-6500** [**https://www.hhs.texas.gov/**](https://www.hhs.texas.gov/) **2024**