





**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:** |
|  |
|  |
|  |

|  |  |
| --- | --- |
| **Referred by:**  | **Date:**   |
| **Address:**  |
| **Phone:**  |
| **Please email referral along with current eye report and IEP (ARD) to:** **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**