**Washington State Authorized School Bus Driver**



**Diabetes Exemption Program**

**Vision Evaluation Section**

**Driver Information**

Last Name: First Name: MI:

Address:

City: State: ZIP code:

DOB (MM/DD/YYYY): \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

This individual is applying for an original or continuing to maintain a Washington State school bus driver diabetes exemption to be able to take insulin while operating a school bus in Washington State. Part of the application process is an eye examination (required on an annual basis) by an ophthalmologist or optometrist to determine if the individual has any vision problem that might impair safe driving. **Note: If the applicant has retinopathy, an ophthalmologist examination is required.**

PLEASE CHECK/FILL IN REQUESTED INFORMATION.

1. I am an ophthalmologist [ ]  I am an optometrist [ ]
2. Date of most recent examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Distant visual acuity (please provide both if applicable):

UNCORRECTED [ ]  CORRECTED [ ]

[ ]  Glasses

[ ]  Contact Lens

Right eye: 20/\_\_\_\_\_ 20/\_\_\_\_\_

Left eye: 20/\_\_\_\_\_ 20/\_\_\_\_\_

1. Field of vision (FOV)\*:

Right eye: \_\_\_\_\_\_\_\_\_\_\_degrees (a quantitative evaluation is required)

Left eye: \_\_\_\_\_\_\_\_\_\_\_degrees (a quantitative evaluation is required)

Test used to determine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Note: If the patient has received laser treatment, and in your medical opinion you believe the patient’s FOV is compromised, Federal Motor Carrier Safety Administration (FMCSA) recommends formal perimetry to determine if the driver meets the FOV standard.

1. Color Vision:

Is the patient able to identify correctly the standard red, green, and amber traffic control signal colors? YES [ ]  NO [ ]

Driver’s Last Name:       Driver’s First Name:

Note: If color testing results are inconclusive, it is discretionary whether to administer a controlled test using an actual traffic signal to determine the individual’s ability to recognize red, green, and amber.

An applicant with diabetic retinopathy must be evaluated by an ophthalmologist. The vision examination must occur AFTER any eye surgery/procedures (postoperatively).

1. Does the patient have diabetic retinopathy? YES [ ]  NO [ ]

If yes: Proliferative

 Stable [ ]  Unstable [ ]

Nonproliferative

 Stable [ ]  Unstable [ ]

Treatment:

Date diagnosed:

Surgery/procedures:

Requires recheck in \_\_\_\_ months

1. Does the patient have macular edema? YES [ ]  NO [ ]
2. Does the patient have cataract(s)? YES [ ]  NO [ ]
3. Does the patient have any other medical diagnosis related to vision?

YES [ ]  NO [ ]

 If yes, what?

1. If yes to any of the conditions listed above, are any unstable?

YES [ ]  NO [ ]

 If yes, which condition(s)?

1. In your medical opinion, is monitoring required more often than annually?

YES [ ]  NO [ ]

 If yes, how often?

1. In your medical opinion, does the patient possess any vision problem that might impair safe driving?

YES [ ]  NO [ ]

 If yes, please explain

1. I hereby certify that in my medical opinion, the applicant’s medical condition allows them to safely operate a school bus, while using insulin for the control of diabetes mellitus.

 YES [ ]  NO [ ]

Driver’s Last Name:       Driver’s First Name:

1. Ophthalmologist or Optometrist Identification:

(please print)

Last name: First Name:

Medical license number: State of issue:

Signature: Date:

 (Part C is valid for 12 months from the date the physician signs this form.)