SCHOOL HEALTH PROGRAM
EYE SPECIALIST REPORT

Student: _____ Homeroom: _____

Date of Exam: _____

Visual Acuity:	FAR		NEAR	
	Right	Left	Right	Left
Without Correction	_____	_____	_____	_____
With Correction	_____	_____	_____	_____

Diagnosis or explanation of eye condition:

_____

_____

Plan of Treatment:

Glasses Prescribed	Yes _____	No _____
Constant Wear	Yes _____	No _____
Near Work Only	Yes _____	No _____
Distance Work Only	Yes _____	No _____
Contact(s) Prescribed	Yes _____	No _____

Recommendation for School:

_____

_____

Return Visit: _____

_____
Print Name of Eye Care Specialist

_____
Signature of Eye Care Specialist

_____
Telephone

(RETURN REPORT TO SCHOOL NURSE)