SCHOOL HEALTH PROGRAM

EYE SPECIALIST REPORT

Student's Name ____ Date __________

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

(Return report to School Nurse)

____
Signature of Eye Care Specialist

____
Telephone