REPORT OF EYE EXAMINATION
PLEASE RETURN TO Nyack Middle School 98 So. Highland Ave, Nyack, NY 10960
Att: SCHOOL HEALTH OFFICE, Miriam Lynn, RN

NAME OF STUDENT: _____ Grade _____ DOB _____
Print Name

DATE OF EXAMINATION: _____

	Without Lens	With Lens
Distance Acuity:	Right eye 20/	Right eye 20/
	Left eye 20/	Left eye 20/
Near Acuity:	Right eye 14/	Right eye 14/
	Left eye 14/	Left eye 14/

Other Tests Performed: Test Name Results

_____

_____

_____

Lens Requirements: Frequency of Use:

_____ Correction Not required _____ Wear at all times

_____ Wear for class work

_____ Wear for distance only

_____ Correction prescribed _____ Glasses _____ Contact Lens

Corrected Visual Acuity: Right eye 20/_____ Left eye 20/_____

Recommendations: (Special seating, large print and/or other visual aids, special education referral, impact resistant glasses, physical education modifications, etc.)

_____

_____

_____

Date of Next Appointment: _____

Examiner's Signature: _____

Address (stamp please) _____

_____

_____

Telephone _____

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