EYE GLASSES/CONTACTS FORM

Dear Parent or Guardian,
To have a better understanding of your child's vision it is important for you to let the school nurse know what if any restrictions are to be in effect in regard to their glasses. Please consult your eye specialist or physician and have them fill in the form below. **PLEASE RETURN THIS FORM TO THE SCHOOL NURSE.** Thank you for your cooperation.

_____ _____ _____
Print Name Date Grade

1. Diagnosis _____
2. Under what conditions should glasses or contacts be worn? _____

   _____
3. Should glasses/contacts be worn during gym/recess? Yes _____ No _____
4. Should physical activities be limited because of eye condition? Yes ____ No ____
5. Are glasses/contacts to be worn for all class work? Yes _____ No _____
6. Are glasses/contacts to be worn for reading? Yes _____ No _____
7. Are glasses/contacts to be worn for writing? Yes _____ No _____
8. Are glasses/contacts to be worn for board work? Yes _____ No _____
9. Other: _____
10. Have shatterproof lenses been recommended? Yes _____ No _____
11. If field of vision is restricted, indicate degree and location: _____

    _____
12. When should this pupil be re-examined? _____

Exam findings:

Near Vision: R _____ L_____ Near Vision Corrected: R _____ L _____

Distance Vision: R _____ L _____ Distance Vision Corrected: R _____ L _____

_____ _____
Examiner's Signature and Title Exam Date Examiner's Stamp:

Thank you,
Nyack Public School Nurses