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