SCHOOL HEALTH PROGRAM
EYE SPECIALIST REPORT

Student: ______________________ Homeroom: ________

Date of Exam: ________________

Visual Acuity: **FAR** **NEAR**

	FAR Right	FAR Left	NEAR Right	NEAR 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)