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:

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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:

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Return Visit: ____

____
Print Name of Eye Care Specialist

____
Signature of Eye Care Specialist

____
Telephone Number

Return Report to School Nurse