Lawrenceburg Primary School
Comprehensive Eye Exam

IDENTIFYING INFORMATION (parents please complete this section)

Student's Name_____ Date of Birth_____

Parent or Guardian Name_____

Student's Grade (please circle) **Kindergarten** **First** **Second**

SCREENING

Any past or current ocular history or complaints? (EXPLAIN)

_____

_____

_____

Screened with glasses? (please circle) Yes (or) No

Visual Acuity R_____/ L_____ Retinoscopy: Pass (or) Fail

Ocular Health Pass (or) Fail Cover Test: Pass (or) Fail

Results: Pass (or) Fail Borderline

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_____

Optometrist/Ophthalmologist Signature_____Date_____

Return to the School Nurse **Phone– 812-537-7239** **Fax– 812-537-5746**