SCHOOL HEALTH PROGRAM

EYE SPECIALIST REPORT

Student's Name ______________________________ Date: ______________

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

	FAR Right / Left	NEAR 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