Vision Examination Report

TO BE COMPLETED FOLLOWING SCREENING

TEST GIVEN
1. Instrument Used
   a. [ ] Visual Acuity
   b. [ ] Plus Sphere
   c. [ ] Muscle Balance
   d. [ ] Near and Far Binocular Vision
   e. [ ] Other: ________________________________

REASON FOR REFERRAL
1. [ ] Visual Acuity
2. [ ] Plus Sphere
3. [ ] Muscle Balance – Phoria
4. [ ] Near and Far Binocular Vision – Fusion

SYMPTOMS NOTED
1. [ ] Academic Achievement
2. [ ] Observable Signs: ________________________________

TO THE DOCTOR

CHILD WEARING GLASSES OR UNDER CARE

Children wearing glasses or under care are not screened as part of the routine vision screening program. Observations by screening technicians possibly indicate the following:

- [ ] Frames broken / too small
- [ ] Two years since last examination
- [ ] Lenses scratched / broken
- [ ] Other: ________________________________

TO BE COMPLETED BY EXAMINING DOCTOR

DISTANCE

<table>
<thead>
<tr>
<th>(1) UNCORRECTED VISUAL ACUITY</th>
<th>(2) BEST CORRECTED VISUAL ACUITY</th>
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<tbody>
<tr>
<td>RIGHT</td>
<td>LEFT</td>
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(3) Oculomotor Assessment

(4) Diagnosis

(5) Comments

PLEASE CHECK IF APPROPRIATE:

- [ ] Treatment recommended
- [ ] Medical
- [ ] Glasses
- [ ] Contact Lenses
- [ ] Other: ________________________________

- [ ] Corrective lens prescribed
- [ ] Constant Wear
- [ ] Near Vision only
- [ ] Far Vision only
- [ ] May be removed for physical education

- [ ] Visual field restriction
- [ ] Amblyopia exists
- [ ] Muscle imbalance exists
- [ ] Close work may be difficult or cause fatigue
- [ ] Preferential seating needed
- [ ] Re-examination advised
- [ ] Six months
- [ ] Twelve months
- [ ] Other: ________________________________

Please print or stamp

Doctors Name

Address

City

Date of Examination

CONSENT OF PARENT OR GUARDIAN

I agree to release the above information on my child or ward to appropriate school or health authorities.

PARENT OR GUARDIAN’S SIGNATURE

DOCTOR’S SIGNATURE