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:

_____

_____

_____

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