

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