

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: _____

(Return report to School Nurse)_____
Print Name of Eye Care Specialist_____
Signature of Eye Care Specialist_____
Telephone