We strongly recommend a professional vision exam and the completion of this form.

Report of Professional Eye Examination to the School

Student name_____DOB_____

Grade _____ Date of examination_____

Visual Acuity **Distance** Without correction: R_____ L_____

With Correction R_____ L_____

Visual acuity: **Near** Without correction R_____ L_____

With Correction R_____ L_____

Peripheral vision, if fields are restricted, indicate degree and location: _____

Diagnosis: _____

Plan: ☐ No treatment at this time ☐ Eyeglasses ☐ Contact Lenses ☐ Patch
☐ Other_____

Please indicate when or under what conditions corrective lenses/patch should be worn:

Requirements: _____ Correction not required
_____ Correction prescribed
_____ Glasses _____ contact lenses

Corrected Visual Acuity: R 20/_____ L 20/_____

Frequency of Classroom Use:
_____ Wear at all times. _____ Wear for distance only
_____ Wear for reading tasks only _____ Other (specify)_____

Physical Education: (Note: Only polycarbonate lenses are acceptable for wear during physical education)
_____ Wear for physical education _____Remove for physical education

Signature/Title_____

Telephone number_____