

P R E S C H O O L

Comprehensive Eye and Vision Examination Report

Child's Last Name _____ First Name _____ M.I. _____ School Year ____/____
Address _____ Date of Birth ____/____/____ Age ____
Parent's Name _____ Phone (____) _____
Name of Preschool/Day Care Facility _____

Summary of Findings for the Parent and Teacher

EYE HEALTH: Internal and external ocular health evaluation. Normal Abnormal GLAUCOMA: Absent Present

VISUAL ACUITY:	At Distance			At Reading Distance _____ inches		
Without Correction:	R.Eye 20/	L.Eye 20/	Both 20/	R.Eye 20/	L.Eye 20/	Both 20/
With Best Correction:	R.Eye 20/	L.Eye 20/	Both 20/	R.Eye 20/	L.Eye 20/	Both 20/

VISUAL EFFICIENCY: Functioning of the two eyes to enable comfortable, efficient visual performance at all distances.

- DEPTH PERCEPTION:** Ability to use both eyes together to perceive and judge depth or relative distances.
(Stereopsis Test) Adequate Inadequate Remarks _____
- MUSCLE IMBALANCE:** Absent Present Near work may be difficult or cause fatigue. Remarks _____
- OCULOMOTOR EVALUATION:** Ability of the eyes to move in all directions at an age appropriate level. Adequate Inadequate
- SUPPRESSION OF VISION:** A mental blocking by the brain of the image seen by an eye that does not function properly. Absent Present
- AMBLYOPIA:** A loss of vision. None Right Eye Left Eye Remarks _____
- COLOR VISION:** Ability to distinguish colors accurately. Normal Deficient Remarks _____
- REFRACTIVE EVALUATION:** Ability of the eyes to focus light accurately on the retina. Normal Myopia Hyperopia Astigmatism

DIAGNOSIS: Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia Muscle Imbalance
 Convergence Insufficiency Accommodative Dysfunction Oculomotor Deficiency Glaucoma Other _____

No Treatment Indicated Treatment Recommended Present Prescription Satisfactory New Prescription Ordered
 Contact Lenses Prescribed Vision Therapy Medical Other Remarks _____

Glasses Should Be Worn: Constantly Near Vision Far Vision May be removed for Physical Education or Recess

*** If applicable: Meets the vision requirements for Driver Education. Without Correction With Correction (glasses/contacts)

CLASSROOM RECOMMENDATIONS: Preferential seating needed. Other helpful comments: _____

RE-EXAMINATION ADVISED: 6 Months 12 Months Other _____ Date of Examination _____

Signed _____ Diagnosis Code _____
Optometrist or Ophthalmologist O.D. M.D. D.O. License Number _____
(Circle One)
Address _____ Phone (____) _____

IMPORTANT NOTICE: Vision screening is *not a substitute* for a complete eye and vision evaluation by an eye doctor. A child should not be required to undergo a vision screening if an optometrist or ophthalmologist completed and signed a report form indicating an examination had been administered within the previous 12 months. **Consent of Parent:** I agree to release the above information on my child to appropriate school or health authorities.

PARENT'S SIGNATURE _____ **Date** _____