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VISIONfirst FOUNDATION

STUDENT
Comprehensive Eye and Vision Examination Report

Student's Last Name_____ **First Name**_____ **M.I.**____ **School Year**_____/_____

Address_____ **Date of Birth**____/____/____ **Age**____

Parent's Name_____ **Phone (_____)**_____

School_____ **Grade**____ **Homeroom Teacher**_____ **Room**_____

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.

1. **DEPTH PERCEPTION:** Ability to use both eyes together to perceive and judge depth or relative distances.
   (Stereopsis Test) ☐ **Adequate** ☐ **Inadequate** Remarks _____
2. **MUSCLE IMBALANCE**: ☐ **Absent** ☐ **Present** ☐ Near work may be difficult or cause fatigue. Remarks_____
3. **OCULOMOTOR EVALUATION**: Ability of the eyes to move in all directions at an age appropriate level. ☐ **Adequate** ☐ **Inadequate**
4. **SUPPRESSION OF VISION**: A mental blocking by the brain of the image seen by an eye that does not function properly. ☐ **Absent** ☐ **Present**
5. **AMBLYOPIA**: A loss of vision. ☐ **None** ☐ **Right Eye** ☐ **Left Eye** Remarks_____
6. **COLOR VISION:** Ability to distinguish colors accurately. ☐ **Normal** ☐ **Deficient** Remarks_____
7. **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. (Circle One) License Number

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**_____

 www.VisionFirstFoundation.org

Approved for distribution by Name of School, Eye Clinic, or Organization.

Custom #CSR101-US