S T U D E N T
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

CASE HISTORY/REASON FOR VISIT:_____

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

VISUAL ACUITY: A measure of the ability of the eyes to see well at both far and near distances.

	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/

REFRACTIVE EVALUATION: Measurements for eyeglass prescriptions including nearsightedness, farsightedness, and astigmatism.

☐ **No Refractive Error** ☐ **Nearsightedness (**Myopia) ☐ **Farsightedness** (Hyperopia**)** ☐ **Astigmatism** Comments_____

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

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

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 Comments_____

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 comments:_____

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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**_____