

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

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: _____

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** _____