



Name \_\_\_\_\_  
(Last)  
(First)  
(Initial)

Date \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ County \_\_\_\_\_

Testing Location \_\_\_\_\_ Testing Agency \_\_\_\_\_ Tester \_\_\_\_\_

TO BE COMPLETED FOLLOWING SCREENING

TEST GIVEN

1. Instrument Used \_\_\_\_\_
- a.  Visual Acuity
  - b.  Plus Sphere
  - c.  Muscle Balance
  - d.  Near and Far Binocular Vision
  - e.  Other: \_\_\_\_\_

REASON FOR REFERRAL

- 1.  Visual Acuity
- 2.  Plus Sphere
- 3.  Muscle Balance – Phoria
- 4.  Near and Far Binocular Vision – Fusion

SYMPTOMS NOTED

- 1.  Academic Achievement
- 2.  Observable Signs: \_\_\_\_\_

TO THE DOCTOR

CHILD WEARING GLASSES OR UNDER CARE



Children wearing glasses or under care are not screened as part of the routine vision screening program. Observations by screening technicians possibly indicate the following:

- Frames broken / too small
- Lenses scratched / broken
- Two years since last examination
- Other: \_\_\_\_\_

TO BE COMPLETED BY EXAMINING DOCTOR

DISTANCE

(1)	UNCORRECTED VISUAL ACUITY		(2)	BEST CORRECTED VISUAL ACUITY	
	RIGHT	LEFT		RIGHT	LEFT

PLEASE CHECK IF APPROPRIATE:

- (3) Oculomotor Assessment \_\_\_\_\_
- (4) Diagnosis \_\_\_\_\_
- (5) Comments \_\_\_\_\_

- Treatment recommended
  - Medical
  - Glasses
  - Contact Lenses
  - Other: \_\_\_\_\_
- Corrective lens prescribed
  - Constant Wear
  - Near Vision only
  - Far Vision only
  - May be removed for physical education
- Visual field restriction
- Amblyopia exists
- Muscle imbalance exists
  - Close work may be difficult or cause fatigue
- Preferential seating needed
- Re-examination advised
  - Six months
  - Twelve months
  - Other: \_\_\_\_\_

Please print or stamp

Doctors Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Date of Examination \_\_\_\_\_

CONSENT OF PARENT OR GUARDIAN

I agree to release the above information on my child or ward to appropriate school or health authorities.

\_\_\_\_\_  
PARENT OR GUARDIAN'S SIGNATURE

\_\_\_\_\_  
DOCTOR'S SIGNATURE