EYE SPECIALIST REPORT

Student's Name _____ Date _____

Visual Acuity: FAR NEAR

	Right	Left	Right	Left
Without Correction	_____	_____	_____	_____
With Correction	_____	_____	_____	_____

Diagnosis or explanation of eye condition:

_____

_____

_____

Plan of Treatment:

Glasses Prescribed	Yes _____	No _____
Constant Wear	Yes _____	No _____
Near Work Only	Yes _____	No _____
Distance Work Only	Yes _____	No _____
Contact(s) Prescribed	Yes _____	No _____

Recommendation for school:

_____

_____

_____

Return visit: _____

_____
Signature of Eye Care Specialist

_____
Print Name of Eye Care Specialist

_____

_____
Address

_____
Telephone

RETURN REPORT TO SCHOOL NURSE