EYE CARE 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: _____

_____
PRINT NAME OF EYE CARE SPECIALIST

_____
SIGNATURE

_____
TELEPHONE

PLEASE RETURN THIS FORM TO SCHOOL - ATTENTION: SCHOOL NURSE

SCHOOL NAME:_____

ADDRESS: _____

ZIP CODE: _____

OR FAX TO:_____

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