EYE SPECIALIST REPORT

Student's Name: ______________________________________ **Date**____________

Visual Acuity: FAR NEAR

	FAR Right / Left	NEAR Right / Left
Without correction:	_____ _____	_____ _____
With correction:	_____ _____	_____ _____

Convex Lens (excessive farsightedness): Pass: ___________ Fail: ____________

Stereo/Depth Perception: Pass: ___________ Fail: ____________

Color Vision: Pass: ___________ Fail: ____________

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 date: ____________________

____
Print Name of Eye Care Specialist

(Return report to School Nurse)

____
Signature of Eye Care Specialist

Cambria Heights School
Fax# (814) 344-6274

____
Telephone