Office Address
&
Logo

Vision Exam Report Form: *School Copy*

Name_____ **Date of Birth** _____

Visual Acuity: Right eye with glasses _____ Right eye without glasses _____
Left eye with glasses _____ Left eye without glasses _____
Alignment: ❒ straight _____ tropia _____ phoria
Diagnosis: _____ Prescription: _____

❒ No further evaluation is necessary at this time
❒ Follow-up is recommended in _____ month(s) year(s)

The following educational considerations are recommended:

- ❒ Preferential seating in classroom: Where _____
- ❒ Glasses to be worn at all times
- ❒ Glasses to be worn part time, primarily for ❒ reading ❒ distance
- ❒ Full participation in Physical Education classes
- ❒ Restricted Physical Education: Restrictions _____

Other _____

Signature: _____ Name (print): _____
Date of exam: _____

Dear Parent/Guardian, Please bring this completed form to your child's school. Thank you.

==========*cut along dotted line*==========

Office Address
&
Logo

Exam Report Form: *Primary Care Provider Copy*

Name: _____ Date of Birth _____

Dear Primary Care Physician,
Your patient was seen for a comprehensive eye examination on (date) _____ by (name and discipline)

Visual acuity: Right Eye:	❒ Pass	❒ Refer
Left Eye:	❒ Pass	❒ Refer
Stereopsis (alignment):	❒ Pass	❒ Refer

❒ No further evaluation is necessary at this time
❒ Follow-up is recommended in _____ month(s) year(s)

Signature: _____ Name (print): _____

Dear Parent/Guardian, Please bring this completed form to your child's pediatrician, family physician, or other primary health care provider. Thank you.