Ferndale Area School District
**SCHOOL HEALTH PROGRAM**

Student's Name: ___________________________________ Date: ____________________

Visual Acuity: **FAR** **NEAR**

| | FAR Right / Left | NEAR 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

**(Return Report to School Nurse)**

______________________________________
Signature of Eye Care Specialist

______________________________________
Telephone