FERNDALE AREA SCHOOL DISTRICT
SCHOOL HEALTH PROGRAM

EYE SPECIALIST REPORT

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
Contacts Prescribed	Yes	No

Recommendation for School:

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Return Visit: ____

____
Print Name or Eye Care Specialist

(Return Report to School Nurse)

____
Signature of Eye Care Specialist

____
Telephone