SCHOOL HEALTH PROGRAM
EYE SPECIALIST REPORT

Child's Name:
Address:

DOB:

Age:

Grade:

School: **Millville**

Visual Acuity:	**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: _____

_____ _____

Signature of Eye Care Specialist Date of examination

_____ _____

Print Name of Eye Care Specialist Telephone

(Please return report to School Nurse)