SCRANTON SCHOOL DISTRICT

SCHOOL HEALTH PROGRAM

EYE SPECIALIST REPORT

Student's Name ______________________________ Date: ____________________

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: ____

____
Print Name of Eye Care Specialist

(Return report to School Nurse)

____
Signature of Eye Care Specialist

____
Telephone Number