

**PARKLAND SCHOOL DISTRICT
HEALTH SERVICES**

EYE SPECIALIST REPORT

Student's Name _____

Date: _____

Visual Acuity:

FAR

NEAR

	Right/Left	Right/Left
Without correction:	___ ___	___ ___
With correction:	___ ___	___ ___

Diagnosis or explanation of eye condition:

Plan of Treatment:

Glasses Prescribed	Yes _____	No _____
Prescription Changed	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: _____

(Return report to School Nurse)

Print Name of Eye Care Specialist

Signature of Eye Care Specialist

Telephone