SCHOOL VISION REPORT

Student _____ Reason for Visit: Pre-School Visit

Grade _____ Teacher _____ Date of Examination_____

SUMMARY

A. Eye Health: Normal Abnormal Comments _____

B. Visual Acuities: Right Left

Uncorrected	_____	_____
Corrected	_____	_____

C. Refractive Error:

_____ Hyperopia (farsightedness)
Is is greater than +1.5 OD? _____ Yes _____ No
_____ Myopia (nearsightedness)
Is it greater than -1.0 OD _____ Yes _____ No
_____ Astigmatism Is it greater than 1.0 OD? _____ Yes _____ No

D. Binocularity:
Distance Phorias: None _____ Eso _____ Exo _____
Near Phorias: None _____ Eso _____ Exo _____
Tropias _____
Convergence_____
Stereopsis _____

E. Color Perception: _____ Pass _____ Fail

F. Recommendations:

_____ No treatment needed
_____ Glasses _____ Fulltime wear _____ Reading only _____ Other
_____ Visual Therapy:
Please describe briefly_____
_____

G. Re-examination is recommedned in: _____ months _____ year(s)

H. Comments: _____
_____

Eyecare Practitiioner Name _____
Address _____

Signed_____