

VISION REPORT FROM EYE DOCTOR

Student's Name: _____ Date of Birth: _____

1. Ocular History, (include ocular surgeries, etiology, age of onset and genetic factors):

2. Visual Acuity:

	<u>DISTANCE VISION</u>				<u>NEAR VISION (at distance noted)</u>			
	without correction	with best correction			without correction	with best correction		
O.D.	_____	_____	_____	at	_____	_____	at	_____
O.S.	_____	_____	_____	at	_____	_____	at	_____
O.U.	_____	_____	_____	at	_____	_____	at	_____

A. If a visual acuity measure was not possible, what is your opinion regarding what the child sees?

Are there any concerns in the following areas? If so, please describe.

YES	NO		DESCRIBE
☐	☐	Visual Field	_____
☐	☐	Focus	_____
☐	☐	Ocular alignment	_____
☐	☐	Tracking	_____
☐	☐	Color perception	_____
☐	☐	Contrast sensitivity	_____
☐	☐	Photophobia	_____
☐	☐	Intra-ocular pressure	_____
☐	☐	Visual fatigue	_____
☐	☐	Depth perception	_____

3. Prognosis and Recommendations:

A. Child's condition is: Stable _____ Deteriorating _____
Capable of improving _____ Uncertain _____

B. Treatment recommended: _____

C. Corrective lenses: Not needed ____ Prescribed ____ To be worn constantly ____
For close work _____ Other (specify) _____
Prescription OD _____ OS _____

D. If it is advisable to restrict physical activities, please specify limitations:

E. The next re-examination of this child should be: _____

F. Other considerations which would be beneficial to this child: _____

G. LIU Teacher's Name: _____

Signature of Doctor

Date: _____

Address: _____

Phone Number: _____

Email: _____