Name of student _____ DOB _____ Age _____
Grade_____ School _____
Parent Name _____ Date of exam _____

Please complete every blank of this form!

Visual Acuity (*mark all that apply*)

	Distance		Near	
Without Rx:	(R) 20/_____	(L) 20/_____	(R) 20/_____	(L) 20/_____
With old Rx:	(R) 20/_____	(L) 20/_____	(R) 20/_____	(L) 20/_____

Old Rx OD: _____ No Rx 1
OS: _____

Cover Test
Distance: _____
Near: _____

Correction worn (*check one*) No Rx 1, Old Rx 2, New Rx 3

Color Perception (*males only*) Normal 1, Deficient 2

Refraction (*check one*) Cycloplegic 1, Non-cycloplegic 2
OD: _____ 20/_____
OS: _____ 20/_____

Final Prescription
OD: _____
OS: _____
Add: _____

Diagnoses (*mark all that apply*)
1 Amblyopia
2 Strabismus
3 Convergence problems
4 Accommodation problems
5 Ocular health: _____
6 Other: _____
7 Other: _____
8 Other: _____

Exam was paid by
1 Private Pay
2 Medical Insurance
3 Vision Insurance
4 Lions Club
5 Free Exam by Doctor
6 Other: _____

Name of student _____ DOB _____ Age _____
Grade_____ School _____
Parent Name _____ Date of exam _____

Recommended Treatment

No treatment indicated

Present corrective lenses are satisfactory

New corrective lenses have been recommended and should be worn:
- Constantly
- Classroom
- Near only
- Distance only
- Sports
- Computer

A program of amblyopia treatment has been implemented
- Eye drops, so the *(circle one)* R / L pupil will be dilated all of the time
- Eye patch should be worn on the *(circle one)* R / L eye; how often? _____
- Other _____

Return to this office on _____ (*date*) for
- Prescription check
- Vision therapy
- Amblyopia therapy
- Other _____

Refer to another doctor for
- Ocular health
- Vision therapy
- Amblyopia therapy
- Other _____

Additional special recommendations for classroom interaction

_____
_____
_____
_____
_____

Signature _____(O.D.) (D.O.) (M.D.)
Print Name _____
Practice Name _____
Address _____
City, State Zip _____
Phone Number _____ Fax Number _____

HIPAA Information Release Form

As parent or guardian of the student named above, I authorize the eye care provider listed to disclose (by mail or by facsimile) the results of the HB 95 Eye Exam Report for IEP to my child's school:

Name of School _____ Attention _____
Address _____
City _____ State _____ Zip_____
Telephone _____
Fax _____

The purpose of disclosing the Eye Exam Report is for use in connection with my child's Individualized Education Program (IEP).

I understand that authorized persons associated with my child's school (or school system) may have access to, and use of, the Eye Exam Report for the purpose described above.

I understand that while in possession of authorized school personnel, the Eye Exam Report is not covered by HIPAA. Instead, it is an "education record," whose privacy, use and disclosure is protected by the Family Educational Rights and Privacy Act ("FERPA").

I understand that my refusal to sign this Authorization will not affect my child's ability to obtain treatment from the eye care provider listed above.

I understand my right to inspect or copy information disclosed by this Authorization.

I understand I may revoke (cancel) this Authorization at any time. Revocation must be in writing. The eye care provider cannot be held responsible for having disclosed information in reliance of this Authorization before receiving a written revocation.

I release the eye care provider from legal liability for disclosing The Eye Exam Report (and Protected Health Information contained in it) as authorized by my signature below.

This Authorization will expire on:

Date _____ or
Event _____

_____
Signature of Parent or Guardian

_____
Print Name

Date _____