

# Eye Health Clinic Report



<b>Section 1: Demographics</b>						
Student Name: _____			DOB: _____			
School System: _____			Date of Current Eye Exam: _____			
<b>Section 2: Eligibility for Vision Services and Federal Quota Fund Registration (mark all that apply)</b>						
<input type="checkbox"/> <b>Visually Impaired (VI)</b> 20/70 or less in the better eye after correction or there is a limited visual field that could adversely affect educational progress. <input type="checkbox"/> <b>Meets the Definition of Blindness (MDB)</b> 20/200 or less in the better eye after correction or visual field no greater than 20 degrees. <input type="checkbox"/> <b>Meets the Definition of Blindness (MDB) Immutable Condition</b> (bilateral enucleations, etc) <input type="checkbox"/> <b>Functions at the Definition of Blindness (FDB)</b> Students in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment.						
<b>Section 3: Visual Diagnosis &amp; Prognosis</b>						
Diagnosis: _____						
Prognosis: <input type="checkbox"/> stable <input type="checkbox"/> unstable <input type="checkbox"/> capable of improving <input type="checkbox"/> uncertain						
<b>Section 4: Acuties &amp; Visual Fields</b> <i>If unable to obtain Snellen Acuity, consider the FDB criteria</i>						
	<b>Distance Acuity (ft.)</b>			<b>Near Acuity (in.)</b>		
	O.D.	O.S.	O.U.	O.D.	O.S.	O.U.
<b>Corrected</b>						
<b>Without Correction</b>						
<b>Counts Fingers:</b> <input type="checkbox"/> O.D <input type="checkbox"/> O.S <b>Hand Movement:</b> <input type="checkbox"/> O.D <input type="checkbox"/> O.S <b>Object Perception:</b> <input type="checkbox"/> O.D <input type="checkbox"/> O.S <b>Light Perception:</b> <input type="checkbox"/> O.D <input type="checkbox"/> O.S  <b>Is there a field limitation?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please describe: _____ <i>Please attach diagram of visual fields if tested.</i>						
<b>Section 5: Prescription</b> <i>Complete if glasses and/or contact lenses prescription issued</i>						
<b>OD:</b> sphere _____ Cylinder _____ Axis _____ <b>OS:</b> sphere _____ Cylinder _____ Axis _____ Glasses: <input type="checkbox"/> To be worn constantly <input type="checkbox"/> for close work only <input type="checkbox"/> for distance only <input type="checkbox"/> for protection						
<b>Section 6: Surgery, medications:</b>						
<b>Section 7: Recommendations</b> (lighting levels, restrictions, attach additional pages if necessary)						
<b>Section 8: Authorizations</b>						
Doctor's Name Printed: _____ Name of Practice: _____ Doctor's Signature: _____ MD or OD (circle one) Parent/guardian Signature: _____ Date: _____ <i>I authorize the above person to release this information for educational purposes.</i>						