THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
800 NW 13th Street, Fort Lauderdale, Florida 33311 • Office: 754-321-3453
Exceptional Student Education-Program for the Visually Impaired

Medical Eye Examination Report

This form is used to report the results of a medical eye examination conducted by licensed ophthalmologist, optometrist or neurologist as required by the Florida Department of Education State Board Rules 6A-6.03014 and 6A - 6.0331, F.A.C. when a student is suspected of having a visual impairment. The form is given to the parent or doctor for the doctor to complete and return to the ESE Contact or Teacher of the Visually Impaired (TVI).

Student ID	Student First Name	Student Last Name	DOB	
Grade	**School Name**	**Parent/ Guardian Name**	**Preferred Phone #**	
Home Address		**City**	**State**	**Zip Code**
Email Address				

Medical Eye Examination Results

Date of Exam:	

VISUAL ACUITY

Please provide your best professional estimate of visual functioning/acuity. Complete the box below using Snellen equivalents or NLP, LP, CF, F and F, CSM.

WITHOUT CORRECTION		**WITH BEST CORRECTION**	
Distance (20 feet)	Near (16 inches)	Distance (20 feet)	Near (16 inches)
OD (Right)	OD (Right)	OD (Right)	OD (Right)
OS (Left)	OS (Left)	OS (Left)	OS (Left)
OU (Both)	OU (Both)	OU (Both)	OU (Both)

If the acuity cannot be measured, select the most appropriate estimation:

☐ Legally Blind (20/200 or worse) ☐ Better than 20/70

☐ Between 20/70 and 20/199 ☐ Functions at the Definitions of Blindness (e.g., CVI)

Diagnosis:

Etiology:

Ocular History (previous eye disease, injuries, surgeries, etc.):

Prognosis:

☐ Permanent ☐ Stable ☐ Deteriorating ☐ Can Improve ☐ Unable to Determine ☐ At risk for vision loss

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VISUAL FIELDS

Is there a documented field loss? ☐ Yes ☐ No ☐ Unable to Determine

Visual field loss: ☐ 20 degrees or less ☐ 21 to 30 degrees ☐ no apparent loss

Identified visual field loss: ☐ central ☐ peripheral ☐ scattered ☐ no apparent loss

OTHER VISUAL CONDITIONS

Color Vision ☐ Normal ☐ Impaired
If Impaired, explain:

Muscle Function ☐ Normal ☐ Impaired
If Impaired, explain:

Contrast Sensitivity ☐ Normal ☐ Impaired
If Impaired, explain:

TREATMENT REGIMEN

Prescribe Glasses	☐ None	☐ Worn Constantly	☐ Distance only	☐ Near Only
Prescribed Contact Lenses	☐ Yes	☐ No		
Safety Glasses	☐ Yes	☐ No		
Sunglasses	☐ Yes	☐ No		
Medication	☐ Yes	☐ No		
Surgery	☐ Yes	☐ No		
Prescribed Low Vision Aids	☐ Yes	☐ No		

If yes, add type, strength, and recommendations for use:

Other ☐ Yes ☐ No
If yes, describe:

PRECAUTIONS AND RECOMMENDATIONS

Describe precautions/suggestions for lighting conditions, physical activities to be avoided, etc.:

_____ Date Form Completed

_____ Printed Name of Licensed Ophthalmologist/Optometrist/Neurologist

_____ Physician's Phone Number

_____ Signature of Licensed Ophthalmologist/Optometrist/Neurologist

Return completed, signed form to school, or email to:

Name:		Title/Position:	
School Name:			
Email Address:	BCPS_VIReferral@browardschools.com		