SCHOOL HEALTH PROGRAM
EYE SPECIALIST REPORT

Student's Name _____ Date: _____

Visual Acuity	**Far**	**Near**
With Correction	Right: _____ Left: _____	Right: _____ Left: _____
Without Correction	Right: _____ Left: _____	Right: _____ Left: _____

Diagnosis or explanation of eye condition:

_____

_____

Plan of Treatment:

Glasses Prescribed Yes _____ No _____

Constant Wear Yes _____ No _____

Near Work Only Yes _____ No _____

Distance Work Only Yes _____ No _____

Contact(s) Prescribed Yes _____ No _____

Recommendation for school:

_____

_____

_____
Eye Care Specialist Name (Print)

_____
Eye Care Specialist Name (Signature)

_____
Telephone Number

Please return this form to the school nurse when completed.

Thank you,

Amanda Slezak, CSN, RN

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