VISUAL HEALTH FORM

Good eyesight is recognized as essential to the learning process. It is required that children receive an evaluation of their vision prior to their enrollment in the Kindergarten program.

At the time of the examination, please ask your eye care specialist to complete this statement, and then return it to the school nurse.

Name:_____________________________________________________      Age:___________________

VISUAL ACUITY:  Uncorrected  right eye______  left eye______
                    Corrected  right eye______  left eye______

DEFECT:  Myopia______ Hyperopia______  Astigmatism______
         Binocular co-ordination________  Tropias________
         Phorias______ Convergence______  Supression______
         Stereopsis________  Color Vision______

TREATMENT:  Glasses__________  If required, how are they to be worn?_____________________

_________________________________________________________________

ANY SPECIAL SEATING ARRANGEMENT NEEDED FOR THE CLASSROOM?______________

_________________________________________________________________

REFERRAL:  Medical__________  Surgical_________________
         Visual Training______________  No Rx at present________

RECOMMENDATION FOR RE-EVALUATION:  ____Weeks______Months______Years

COMMENTS:

_________________________________________________________________

Date  ___________________________  Signature of Eye Care Specialist

HEALTHRECVISION