STUDENT VISION REPORT FORM

Dear Parents,

Please have an ophthalmologist/optometrist fill out this form for your child. Please return it to your child's school by the end of May.

NAME OF STUDENT: _____ **AGE:** _____

ADDRESS: _____

SCHOOL: _____

INFORMATION FOR THE TEACHER AND PARENT

(To be completed by ophthalmologist/optometrist)

Problem areas confirmed by ophthalmologist/optometrist

Vision acuity _____
Excessive Farsightedness _____
Muscle Balance _____

☐ Vision Training Prescribed
☐ Glasses NOT indicated
☐ Present Glasses Satisfactory
☐ New Glasses Prescribed

Glasses should be worn:

☐ Constantly	☐ Chalk/Whiteboard work
☐ School Work	☐ Homework
☐ Movies	☐ T.V.
☐ Riding in a car	☐ Other:

Additional information pertinent to student's vision:

_____

_____

CONCLUSION OF EYE EXAMINATION: _____

_____ _____

DATE **EXAMINER'S SIGNATURE**

After completion the teacher should review and then file in student's file.