Student Vision and Eye Health Examination Form

Because 80% of all learning is obtained through vision, it is imperative that your child receive the proper vision and eye health care you can give them. As many as 25% of all children have vision problems significant enough to prevent them from succeeding in school. Moreover, most children don't know they have a vision problem. As adults, we must act on their behalf. **If your child has not had a complete eye examination by an eye care professional in the last 12-24 months, please make an appointment for them today and give them every opportunity to excel in the classroom.**

Date of Exam:_____ Student's Name:_____ Teacher/Grade_____
(Please Print)

Please complete the following information. *Thank You.*

UNCORRECTED

DISTANCE	NEAR
Visual Acuities	Visual Acuities
RIGHT 20/	RIGHT 20/
LEFT 20/	LEFT 20/
BOTH 20/	BOTH 20/

CORRECTED

DISTANCE	NEAR
Visual Acuities	Visual Acuities
RIGHT 20/	RIGHT 20/
LEFT 20/	LEFT 20/
BOTH 20/	BOTH 20/

DIAGNOSIS FROM VISION TESTING/REFRACTION:

Myopia (Nearsightness)	☐ **Mild**	☐ **Moderate**	☐ **High**
Hyperopia (Farsightness)	☐ **Mild**	☐ **Moderate**	☐ **High**
Astigmatism	☐ **Mild**	☐ **Moderate**	☐ **High**
Ambylopia	☐ **Mild**	☐ **Moderate**	☐ **High**

COLOR VISION: ☐ **Pass** ☐ **Fail**

VISUAL ABILITIES:

Eye Teaming	☐ **Adequate**	☐ **Inadequate**
Convergence Ability	☐ **Adequate**	☐ **Inadequate**
Focusing Ability	☐ **Adequate**	☐ **Inadequate**
Stereopsis	☐ **Normal**	☐ **Absent**

EYE HEALTH STATUS: ☐ **Normal** ☐ **Abnormal Findings:**_____
☐ **Refer to Specialist**

GLASSES PRESCRIBED: ☐ **Yes** ☐ **No**

IF YES, GLASSES ARE TO BE WORN ☐ **Constantly** ☐ **Distance only** ☐**Reading only**

RECOMMENDED DATE FOR NEXT EXAM:_____

Examining Eye Doctor's Name:_____
(Please Print)

Examining Eye Signature:_____

Address:_____

RETURN FORM TO:

J F Luther Administration Bldg
School Nurse Office
201 Park Street
Fort Atkinson WI 53538
920.563.7805 Fax 920.568.4477

Consent of parent or guardian:
I agree to release the above information on my child to appropriate school authorities.
I also consent to my child obtaining an eye examination.

Signature_____ **Date**_____