

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary Reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular Function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and Vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

- Normal Myopia Hyperopia Astigmatism
 Strabismus Amblyopia Other: _____

Recommendations

- Corrective Lenses: No Yes, glasses or contacts should be worn for:
 Constant Wear Near Vision Far Vision
 May Be Removed for Physical Education/Recess
- Preferential Seating Recommended: No Yes Comments: _____
- Recommend Re-examination: 3 months 6 months 12 months
 Other _____
- _____
- _____

Print Name: _____ Lic. No.: _____
Optometrist or Physician (such as an ophthalmologist)
Who Provided the Eye Examination
 MD OD DO

Address: _____

Phone: _____

Signature: _____
Optometrist or Physician (such as an ophthalmologist)
Who Provided the Eye Examination
 MD OD DO

Date: _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

(Parent's or Guardian's Signature)

Date _____