STUDENT VISION REPORT

Name:_____ Date:_____

Birthdate:_____ District:_____

Address:_____ School:_____

_____ Teacher:_____

Phone#:_____ Grade:_____

This vision examination report is being sent to you for information needed in order to assess this student's educational needs.

I. Date of Examination:_____

II. Visual Acuity: Far_____ Near_____

Without glasses R_____ L_____ Both_____ R_____ L_____ Both_____

With glasses R_____ L_____ Both_____ R_____ L_____ Both_____

III. If glasses are prescribed – Lens prescription_____

Glasses to be worn_____

IV. Binocular Efficiency

Distance: Adequate_____ Remarks_____

Near: Adequate_____ Remarks_____

V. Field of Vision: Degree_____

R._____ L._____

VI. Color Perception: Adequate_____ Inadequate_____

If inadequate, state colors_____

VII. Diagnosis _____

VIII. Prognosis _____

IX. Normal or Limited Physical Activity Recommended_____

X. Date of reexamination _____

Signature of Doctor _____

Address _____

Phone _____

RETURN FORM TO:

_____ _____

(TVI) _____

_____ _____

Fax Number (Address)