## SCHOOL HEALTH PROGRAM

## EYE SPECIALIST REPORT

Student's Name		Date:	
Visual Acuity:	<u>FAR</u>	<u>NEAR</u>	
Without correction:	Right / Left	Right / Left ————	
With correction:  Diagnosis or explanation of eye of	condition:	<del></del>	
Plan of Treatment:			
Glasses Prescribed	Yes	No	
Constant Wear	Yes	No	
Near Work Only	Yes	No	
Distance Work Only	Yes	No	
Contact(s) Prescribed	Yes	No	
Recommendation for school:			
Return visit:			
	_	Print Name of Eye Care Specialist	
(Return report to Schoo	ol Nurse)	Finit Name of Eye Care Specianst	
	_	Signature of Eye Care Specialist	
		Telephone	