CHARTIERS VALLEY
SCHOOL DISTRICT | Inspiring excellence.

SCHOOL HEALTH PROGRAM: EYE SPECIALIST REPORT

Student's Name _____ Date _____

Visual Acuity:

	FAR		***NEAR***	
	Right/	Left	Right/	Left
Without correction	_____	_____	_____	_____
With correction	_____	_____	_____	_____

Diagnosis or explanation of eye condition:

_____

_____

_____

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

_____
Signature of Eye Care Specialist

_____
Telephone