Name of student _____DOB _____ Age _____
Grade_____ School _____
Parent Name _____ Date of exam _____

Visual Acuity (*mark all that apply*)

	Distance		**Near**	
Without Rx:	(R) 20/_____	(L) 20/_____	(R) 20/_____	(L) 20/_____
With old Rx:	(R) 20/_____	(L) 20/_____	(R) 20/_____	(L) 20/_____

Old Rx OD: _____ No Rx □1
OS: _____

Cover Test
Distance: _____
Near: _____

Correction worn (*check one*)
No Rx □1
Old Rx □2
New Rx □3

Color Perception (*males only*)
Normal □1
Deficient □2

Refraction *(check one)*
OD: _____ 20/_____
OS: _____ 20/_____
Cycloplegic □1
Non-cycloplegic □2

Final Prescription
OD: _____
OS: _____
Add: _____

Diagnoses (*mark all that apply*)
□1 Amblyopia
□2 Strabismus
□3 Convergence problems
□4 Accommodation problems
□5 Visual perceptual difficulties
□6 Ocular health: _____
□7 Other: _____
□8 Other: _____

Exam was paid by
□1 Private Pay
□2 Medical Insurance
□3 Vision Insurance
□4 Charitable
□6 Other: _____

Child had a previous eye exam by an eye doctor
□1 Yes
□2 No

Name of student _____DOB _____ Age _____
Grade_____ School _____
Parent Name _____ Date of exam _____

Recommended Treatment

- ☐ No treatment indicated

- ☐ Present corrective lenses are satisfactory

- ☐ New corrective lenses have been recommended and should be worn:
  - ☐ Constantly
  - ☐ Classroom
  - ☐ Near only
  - ☐ Distance only

- ☐ A program of amblyopia treatment has been implemented
  - ☐ Eye drops, so the *(circle one)* R / L pupil will be dilated all of the time
  - ☐ Eye patch should be worn on the *(circle one)* R / L eye; how often? _____
  - ☐ Other _____

- ☐ Return to this office on _____ (*date*) for
  - ☐ Prescription check
  - ☐ Vision therapy
  - ☐ Perceptual training
  - ☐ Amblyopia therapy
  - ☐ Other _____

- ☐ Refer to another doctor for
  - ☐ Ocular health
  - ☐ Vision therapy
  - ☐ Perceptual training
  - ☐ Amblyopia therapy
  - ☐ Other _____

Additional special recommendations for classroom interaction

_____
_____
_____
_____
_____

Signature _____(O.D.) (D.O.) (M.D.)
Print Name _____
Practice Name _____
Address _____
Phone Number _____Fax Number _____