



	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 \_\_\_\_\_