COLONIAL SCHOOL DISTRICT
EYE SPECIALIST REPORT

Student's Name ___________________________ Date _____

Visual acuity:

	FAR	NEAR
Without correction	Right _________	Right __________
	Left _________	Left __________
With correction	Right _________	Right __________
	Left _________	Left __________

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

(Return report to School Nurse)

____
signature of eye care specialist