HEALTH CARE PROVIDER REPORT OF STUDENT'S EYE EXAMINATION

School District of Reedsburg

Student/Estudiante: _____ M F Birthdate/Fecha de Nacimiento: _____

School/Escuela: _____

Parent/Padres: _____ Phone/Teléfono: _____

Complete Address/Dirección Completa: _____

This child has been seen for an eye examination with the following results:

Vision Acuity:	At Distance		At Near	
☐ without correction	R 20/____	L 20/____	R 20/____	L 20/____
☐ with present correction	R 20/____	L 20/____	R 20/____	L 20/____
☐ with new correction	R 20/____	L 20/____	R 20/____	L 20/____

External Eye Health:

☐ Normal ☐ Other

Internal Eye Health

☐ Normal ☐ Other

Vision Analysis:

☐ Normal Eyesight
☐ Eye Teaming Difficulty
☐ Crossed-Eye (strabismus)
☐ Focus Difficulty
☐ Other _____

☐ Nearsighted (myopia)
☐ Farsighted (hyperopia)
☐ Astigmatism
☐ Lazy Eye (amblyopia)

Glasses to be worn:

☐ At all times ☐ For school work ☐ Distance vision ☐ Near vision

☐ Other _____

Signature/Title of Health Examiner: _____ **Date:** _____

Printed or Typed Name of Examiner: _____

Address of Examiner: _____ **Phone Number:** _____

3/11

Please return to School Nurse, 501 K Street, Reedsburg, WI 53959
Por favor devolver a: Enfermera de la Escuela, 501 K Street, Reedsburg, WI 53959