SCHOOL DISTRICT OF REEDSBURG

# EYE EXAMINATION

Student/Estudiante:_____

Birthdate/Fecha de Nacimiento:_____ School/Escuela:_____

Parent or Guardian/Padre o Tutor:_____Phone/Teléfono:_____

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

| **Vision Acuity:** | At Distance | At Near |
|---|---|---|
| ☐ Uncorrected | R20/____ L20/____ | R20/____ L20/____ |
| ☐ Corrected | R20/____ L20/____ | R20/____ L20/____ |

**Overall Eye Health:**

- ☐ Normal
- ☐ Other_____

**Vision Analysis:**

- ☐ Normal Eyesight
- ☐ Eye Teaming Difficulty
- ☐ Crossed-Eye (strabismus)
- ☐ Focus Difficulty
- ☐ Nearsighted (myopia)
- ☐ Farsighted (hyperopia)
- ☐ Astigmatism
- ☐ Lazy Eye (amblyopia)
- ☐ Other_____

**Glasses to be worn:**

- ☐ At all times
- ☐ Near vision
- ☐ Distance vision
- ☐ Other_____

Name/Title of Examiner:_____ Phone:_____

Signature of Examiner:_____ Date:_____

Please return to School Nurse.

Por favor devolver a: Enfermera de la Escuela.