School Board of Broward County, FL

Physician's Report of Eye Examination

Please complete this form and return to your child's school.

Name of Child:_____ Date of Birth:_____

Date of Exam:_____ Diagnosis:_____ Etiology:_____

Child's visual impairment is considered: Stable ___ Degenerative ___ Unknown ___

Visual Acuity

Distance visual acuity without correction: O.D._____ O.S._____O.U._____
Distance visual acuity with best correction: O.D._____ O.S._____O.U._____
Near visual acuity without correction: O.D._____ O.S._____O.U._____
Near visual acuity with best correction: O.D._____ O.S._____O.U._____

Measure of field of vision: _____

Type of refractive error: _____

Treatment Regimen: _____

Recommendations:

Restrictions: _____

Recommended lighting levels:
_____

Glasses: None ___ Constant___ Reading only ___ Distance only___ Protection ___

Additional comments: _____

_____

Print name of eye specialist: _____

Address: _____ Phone: _____

Physician Signature: _____ Title: _____ Date Signed: _____

School Phone: _____School Fax: _____

Form Control # 2902L