READING SCHOOL DISTRICT

Department of Student Services
EYE SPECIALIST REPORT

Student's Name: _____ Date: _____

Visual Acuity	FAR	NEAR
	Right / Left	Right / Left
Without correction:	_____ _____	_____ _____
With correction:	_____ _____	_____ _____

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

_____
Signature of Eye Care Specialist

_____
Telephone Number

(Return report to School Nurse)