ROCHESTER SCHOOL VISION EXAM FORM

NAME: ________________________________ DATE: _______________

PREVIOUS EYE CARE: YES_________ NO_________

SCREENED WITH GLASSES YES_________ NO_________

1. VISUAL ACUITY RIGHT______ LEFT_____
2. COLOR PASS_____ FAIL_____
3. COVER TEST PASS_____ FAIL_____
4. RETINOSCOPY PASS_____ FAIL_____
5. OCULAR HEALTH PASS_____ FAIL_____

REMARKS:____
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RESULTS: PASS_____ BORDERLINE_____ FAIL_____

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SIGNATURE OF EXAMINER

IF CORRECTION IS REQUIRED PLEASE FILL OUT BELOW____

CORRECTED VISUAL ACUITY RIGHT_______ LEFT_______

IF CORRECTIVE LENSES ARE PRESCRIBED, THEY ARE FOR:
CONSTANT WEAR_________ DESK WEAR ONLY________

RE-EXAMINATION ADVISED IN:
6 MONTHS_________ 12 MONTHS_________ OTHER________

SPECIAL COMMENTS AND RECCOMMENDATIONS:
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SIGNATURE OF EXAMINER

Information obtained from this form is protected health information and HIPPAA/FERPA disclosure guidelines will be strictly followed.