Eye Specialist Report to Determine Medical Eligibility for Educational Vision Assessments

NORTHEAST METRO Intermediate School District | 916
partners in education

THIS PORTION OF THE FORM TO BE FILLED OUT BY SCHOOL PERSONNEL

Name of School Personnel Requesting information: _____

Phone number: _____ Fax Number: _____

STUDENT INFORMATION:

Student Name: _____ D.O.B. Sex: ☐ M ☐ F

Street Address: _____ City: _____ State: _____ Zip: _____

School District Number: _____ School: _____

THIS PORTION OF THE FORM TO BE FILLED OUT BY DOCTOR

Your examination information is extremely helpful in meeting the student's educational needs. Thank you for taking the time to fill out the following information.

DIAGNOSIS

Please indicate eye condition primarily responsible for vision loss: _____

_____

_____

Secondary Conditions: _____

_____

_____

Appearance of Eyes (Including Fundi): _____

_____

_____

Prognosis: _____

Should any physical activities of environmental conditions be avoided? ☐ YES ☐ NO

Type: (Please consider gym classes, recess periods, etc) _____

_____

Nystagmus Present? ☐ YES ☐ NO Type:

Color Vision Normal ☐ YES ☐ NO Type of Deficiency:

Photophobia/Light Sensitivity? ☐ YES ☐ NO

VISUAL ACUITY ***DISTANCE VISION*** ***NEAR VISION***

	Without Correction	With Best Correction	Without Correction	With Best Correction
Right Eye (O.D.)				
Left Eye (O.S.)				
Both Eyes (O.U.)				

Was Distance Acuity Tested at: 20 Feet 10 Feet

PRESCRIPTION:

	Sph	Cyl	Axis
Right Eye			
Left Eye			

Is this a change?

YES ☐

NO ☐

If acuity is difficult to obtain, do you estimate the corrected acuity is:

	OD	OS
20/20 – 20/50		
20/60 – 20/100		
20/110 – 20/200		
20/200 – NIL		

For Pre-Kindergarten, measured acuity must be significantly deviant from what is developmentally age-appropriate YES ☐ ☐

VISUAL FIELDS

Were visual fields tested? YES ☐ NO ☐

Method

Please diagram or attach copy of field losses: (Including Scotomas)

If unable to test, do you suspect losses of any type? YES ☐ NO ☐

If yes, please explain (using quadrants if possible)

When should student wear glasses?

When should student be re-examined?

Current Ophthalmological medications prescribed:

Additional Information/comments:

Date of Exam: Date of Report:

Physician (please print/type name)

Address:

Physician Signature: Phone:

Thank you for filling out the form and please remember to
print, sign and fax this form to the school personnel listed above.