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:_____
_____

RESULTS: PASS_____ BORDERLINE_____ FAIL_____

_____
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:
_____
_____
_____

_____
SIGNATURE OF EXAMINER

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