

# 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 RECOMMENDATIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF EXAMINER

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