JEFF TECH
576 VO TECH ROAD
REYNOLDSVILLE, PENNSYLVANIA 15851-6368
(814) 653-8265
FAX: (814) 653-8425

# EYE SPECIALIST REPORT

Student's Name: _____ Date: _____

| Visual Acuity: | FAR | NEAR |
|---|---|---|
| | Right / Left | Right / Left |
| Without correction: | _____ / _____ | _____ / _____ |
| With correction: | _____ / _____ | _____ / _____ |
| Color Perception: | ☐ Pass ☐ Fail | |

Diagnosis or explanation of eye condition:

_____

_____

_____

Plan of Treatment:

| | | |
|---|---|---|
| Glasses Prescribed | Yes _____ | No _____ |
| Constant Wear | Yes _____ | No _____ |
| Near Work Only | Yes _____ | No _____ |
| Distant Work Only | Yes _____ | No _____ |
| Contact(s) Prescribed | Yes _____ | No _____ |

Recommendation for school:

_____

_____

_____

Return Visit: _____

_____
Print Name of Eye Care Specialist

**(RETURN REPORT TO SCHOOL NURSE)**

_____
Signature of Eye Care Specialist

_____
Telephone Number