Western Wayne School District **Eye Specialist Report**

| Student's Name | | Date: | |
|---|------------|----------------------------------|--------|
| Visual Acuity: | <u>FAR</u> | <u>NEAR</u> | |
| Without correction: | Right/Left | Right/Left | |
| With correction: | | | |
| Diagnosis or explanation of eye | condition: | | |
| | | | |
| Plan of Treatment: | | | |
| Glasses Prescribed | Yes | No | |
| Constant Wear | Yes | No | |
| Near Work Only | Yes | No | |
| Distance Work Only | Yes | No | |
| Contact(s) Prescribed | Yes | No | |
| Recommendations for school: | | | |
| | | | |
| Return visit: | | | |
| | | | |
| (Return report to School N 1-800-321-9973) | Nurse | Print Name of Eye Care Specialis | st |
| | | Signature of Eye Care Specialist | t |
| | | Telephone | |