

STUDENT VISION CARD

Student First/Last Name _____ Exam Date _____

Student Date of Birth ____/____/____ Student Home Zip Code _____

TO THE PARENT OR GUARDIAN: To fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. Good vision directly contributes to a child's ability to learn while in school. As a part of your back-to-school preparations, it is recommended that you take your child and this card to your family eye doctor for a complete eye health examination. **This card should be signed by the eye care professional and returned to the school nurse or teacher by your child.**

The following organizations recommend the use of the Student Vision Card



To order more cards call 1-800-444-1772 • www.iowaoptometry.org

Visual Acuity

	At Distance		At Near	
<input type="checkbox"/> Without correction	R20/	L20/	R20/	L20/
<input type="checkbox"/> With present correction	R20/	L20/	R20/	L20/
<input type="checkbox"/> With new correction	R20/	L20/	R20/	L20/

External Eye Health

Normal Other

Internal Eye Health

Normal Other

Vision Analysis

R	L		
<input type="checkbox"/>	<input type="checkbox"/>	Normal eyesight	<input type="checkbox"/> Eye teaming difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Nearsighted (myopia)	<input type="checkbox"/> Crossed-eyes (strabismus)
<input type="checkbox"/>	<input type="checkbox"/>	Farsighted (hyperopia)	<input type="checkbox"/> Eye focusing difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Astigmatism	<input type="checkbox"/> Sensitivity to light
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia	

Other _____

Vision Correction Recommendations

<input type="checkbox"/> No correction necessary	To be worn for:	
<input type="checkbox"/> No change in present prescription	<input type="checkbox"/> Constant wear	<input type="checkbox"/> Near vision only
<input type="checkbox"/> New prescription needed	<input type="checkbox"/> Distance vision only	<input type="checkbox"/> As needed

TO THE EYE CARE PROFESSIONAL: Please sign and date this card after examination.

Dr. Name: (Please Print) _____

Date _____ Signature _____