Clear Form

PHYSICIAN'S REPORT OF EYE EXAMINATION

Print Student's Name (Last) _____ (First) _____ (MI) _____ (Date of exam) _____

Birthdate _____ Sex _____ M _____ F Grade _____ Student ID No. _____

School _____ Parent or Guardian _____

Home Address _____ Phone _____

Background Information/History/Etiology _____

Type of Ocular Defect or Disease (and any secondary eye conditions): _____

_____

Symptoms to Watch for: _____

VISUAL ACUITY

	Distance Vision			Near Vision		
	Without Correction	Current Correction	With Best Correction	Without Correction	Current Correction	With Best Correction
OD (right)						
OS (left)						
OU (both)						

PROGNOSIS AND RECOMMENDATIONS

_____ Stable _____ Deteriorating

What treatment is recommended? _____ Low Vision Examination? (Yes/No) _____

Glasses: Not Needed _____ Constant Wear _____ Close Work Only _____ Other _____

Physical Activity: _____ Unrestricted _____ Restricted as Follows _____

FOR STUDENTS BIRTH TO 5 OR STUDENTS OTHERWISE UNABLE TO BE ASSESSED

If a visual acuity cannot accurately be determined, indicate if the student meets any of the following criteria for program eligibility:

_____ Bilateral lack of central, steady or maintained fixation of vision with an estimated visual acuity of 20/70 or less after best possible correction

_____ Bilateral central scotoma involving the perimacular area (20/80-20/200)

_____ Bilateral grade III, IV, or V Retinopathy or Prematurity or documented eye impairment

---

PLEASE RETURN TO:

_____

_____

_____

PHYSICIAN, PLEASE COMPLETE AND SIGN PAGE 2.

SPECIAL PROGRAMS FOR STUDENTS WHO ARE VISUALLY IMPAIRED

According to State of Florida Administrative Code Rule 6A-6.03014(1)(a-c), the definition of students with visual impairments includes students who are blind or have little potential for using vision, and students who have low vision. The term visual impairment does not include students who have learning problems that are primarily the result of visual perceptual and/or visual motor difficulties.

Rule 6A-6.03014(4)(a)(1-4) for students who are visually impaired mandate the following medical criteria must be met.

In your professional opinion, does this patient meet at least one of the criteria below?
Please indicate which criteria by check mark:

1. ____ A visual acuity of 20/70 or less in the better eye after best possible correction;
2. ____ A peripheral field so constricted that it affects the student's ability to function in an educational setting, not including students who have learning problems that are primarily the result of visual perceptual and/or visual motor difficulties;
3. ____ A progressive loss of vision which may affect the student's ability to function in an academic setting;
4. ____ For children birth to five (5) years of age, bilateral lack of central, steady, or maintained fixation of vision with an estimated visual acuity of 20/70 or less after best possible correction; bilateral central scotoma involving the perimacula area 20/80-20/200; bilateral grade III, IV, or V Retinopathy of Prematurity (ROP); or documented eye impairment as stated in numbers 1, 2, or 3 above. For children birth to five (5) years of age or students who are otherwise unable to be assessed, a medical assessment describing visual functioning shall be documented when standard visual acuities and measure of field of vision are unattainable.

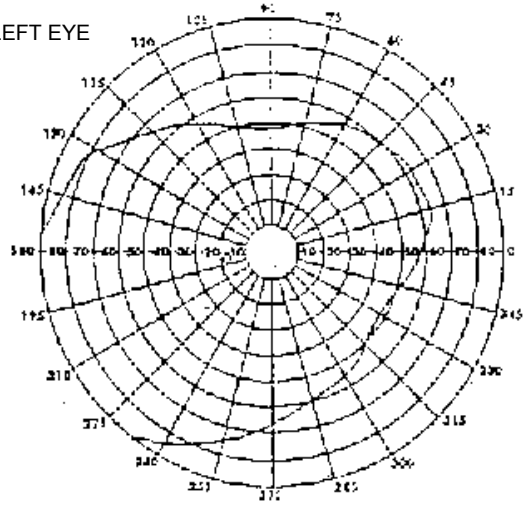
Visual Field

Does the student have a field loss? ____ no ____ yes Describe if loss is present: _____

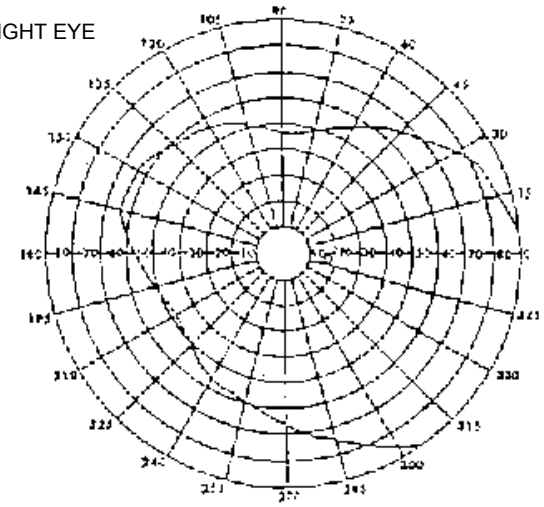
_____

Type of test used _____ Illumination in ft. candles _____

LEFT EYE



RIGHT EYE



Test Object: Color(s) _____ Size(s) _____ Test Object: Color(s) _____ Size(s) _____

Distance(s): _____ Distance(s): _____

_____ _____ _____

Signature of Physician *Date* *Print Name of Physician*

_____ ( ) -

Address and Telephone of Physician

FM-1665 Rev. (05-12)