

**PARKLAND SCHOOL DISTRICT  
HEALTH SERVICES**

**EYE SPECIALIST REPORT**

Student's Name \_\_\_\_\_

Date: \_\_\_\_\_

Visual Acuity:

**FAR**

**NEAR**

	Right/Left	Right/Left
Without correction:	___ ___	___ ___
With correction:	___ ___	___ ___

Diagnosis or explanation of eye condition:

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Plan of Treatment:

Glasses Prescribed	Yes ___	No ___
Prescription Changed	Yes ___	No ___
Constant Wear	Yes ___	No ___
Near Work Only	Yes ___	No ___
Distance Work Only	Yes ___	No ___
Contact(s) Prescribed	Yes ___	No ___

Recommendation for school:

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Return visit: \_\_\_\_\_

**(Return report to School Nurse)**

\_\_\_\_\_  
Print Name of Eye Care Specialist

\_\_\_\_\_  
Signature of Eye Care Specialist

\_\_\_\_\_  
Telephone