WALDWICK PUBLIC SCHOOLS Waldwick, New Jersey 07463 EYE EXAMINATION

Student's Name		Grade		
Date of examination				
Diagnosis				
Vision without correction: OD			OS	
	(far)	(near)	(far)	(near)
Vision with correction:			OS	
	(far)	(near)	OS (far)	(near)
Muscle Balance		Fusion _		
Should the child wear glasses?		When? _		
Has this child ever had eye surger	ry?	Date?		
Recommendation				
Reexamination?		Date?		
			•	
(Physician's name printed)		(Physician's signature)		
(Phone)				