CRESCENT ELEMENTARY SCHOOL

HEALTH OFFICE

EYE EXAMINATION

Date: _____

Student's Name: _____

Date of Examination: _____

Diagnosis: _____

Vision without correction: OD _____ _____ OS _____ _____
(far) (near) (far) (near)

Vision with correction: OD _____ _____ OS _____ _____
(far) (near) (far) (near)

Muscle Balance: _____ Fusion: _____

Should the child wear glasses? _____ When? _____

Has this child ever had eye surgery? _____ Date: _____

Recommendation: _____

_____ _____
Physician's name printed Physician's signature

Physician's stamp