

# 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.**

### 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	
<input type="checkbox"/> Other _____			

### Vision Correction Recommendations

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

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

Dr. Name: (Please Print) \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

The following organizations recommend the use of the Student Vision Card



To order more cards call 1-800-444-1772 • [www.iowaoptometry.org](http://www.iowaoptometry.org)