

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

Without correction

With present correction

With new correction

At Distance

R20/

L20/

R20/

L20/

R20/

L20/

At Near

R20/

L20/

R20/

L20/

R20/

L20/

External Eye Health

Normal Other

Internal Eye Health

Normal Other

Vision Analysis

R

L

Normal eyesight

Nearsighted (myopia)

Farsighted (hyperopia)

Astigmatism

Amblyopia

Eye teaming difficulty

Crossed-eyes (strabismus)

Eye focusing difficulty

Sensitivity to light

Other _____

Vision Correction Recommendations

No correction necessary

No change in present prescription

New prescription needed

To be worn for:

Constant wear

Distance vision only

Near vision only

As needed

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