

# 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"/> No change in present prescription | <input type="checkbox"/> Constant wear        | <input type="checkbox"/> Near vision only |
| <input type="checkbox"/> New prescription needed           | <input type="checkbox"/> Distance vision only | <input type="checkbox"/> 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](http://www.iowaoptometry.org)