COLTON JOINT UNIFIED SCHOOL DISTRICT

VISION EXAMINATION

Parents/Guardians: It is recommended that each child have a professional eye examination when he/she enters school and at intervals thereafter, as recommended.

STUDENT'S NAME _____ DATE _____

ADDRESS _____

SCHOOL _____ GRADE _____ PHONE _____

EXAMINER:
The school will appreciate a report from you and any recommendations you desire to make. This information will be of help in planning the educational program for this child.

EXAMINER'S REPORT TO THE SCHOOL

Visual Acuity		**Glasses**
Without Lenses	**With Lenses**	_____ Not Prescribed
Right 20/_____	Right 20/_____	_____ Prescribed
Left 20/ _____	Left 20/ _____	_____ To be worn for **close work** only
Both 20/ _____	Both 20/ _____	_____ To be worn for **distance only**
		_____ Safety Lenses

Preferential seating recommended: _____

Special materials that would be helpful: _____

Other recommendations or suggestions: _____

Date patient should return for further examination: _____

Examiner's Signature _____ Date _____

Address: _____

NOTE TO EXAMINER: Please return this completed form to the parent to return to school.