South Bend Community School Corporation

Vision Examination (To be filled out by Eye Doctor)
Please return to the school nurse

Please Print
Name: _____ School: _____
Address: _____ Date: _____

Visual Acuity (uncorrected) Right eye 20/_____ Left eye 20/_____

Visual Acuity (corrected) Right eye 20/_____ Left eye 20/_____

	Under convergence	Normal	Over convergence
Muscle Balance	Distance_____	_____	_____
	Near _____	_____	_____
	Adequate_____	Low_____	

		Right eye	Left eye
Refractive State	Normal	_____	_____
	Farsighted	_____	_____
	Nearsighted	_____	_____
	Astigmatism	_____	_____

External Eye Inspection: _____

Internal Eye Inspection: _____

Comments: _____

A complete eye examination is recommended: _____

_____ _____
Doctor's Name (please print) Doctor's Signature