

Child's Name: \_\_\_\_\_

## Dental Examination

Condition of Teeth \_\_\_\_\_

Condition of Gums \_\_\_\_\_

Dr. Signature \_\_\_\_\_

Dr. Name Printed \_\_\_\_\_

Date \_\_\_\_\_

## Optometrist Examination

**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 form to your family eye doctor for a complete eye health examination.

**Para los Padres O Guardian:** Para examinar la salud del sistema visual de su hijo y prevenir problemas de aprendizaje en el futuro asociados con problemas de la vista no detectados, exámenes profesionales de la vista son esenciales. Los expertos estiman que el 80% del aprendizaje es obtenido por medio la vista. Buena visión contribuye directamente a la habilidad de aprender de un niño mientras está en la escuela. Como parte de la preparación de regreso a la escuela se recomienda que lleve a su hijo y esta forma a su aculista familiar para un examen completo de la vista.

### 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

<b>R</b>	<b>L</b>		<b>R</b>	<b>L</b>	
_____	_____	Normal eyesight	_____	_____	Eye Teaming Difficulty
_____	_____	Nearsighted (myopia)	_____	_____	Crossed-eyes (strabismus)
_____	_____	Farsighted (hyperopia)	_____	_____	Eye focusing difficulty
_____	_____	Astigmatism	_____	_____	Sensitivity to light
_____	_____	Amblyopia			

Other: \_\_\_\_\_

### Vision Correction Recommendations

- \_\_\_\_\_ No correction necessary  
\_\_\_\_\_ No change in present prescription  
\_\_\_\_\_ New prescription needed

Dr. Signature \_\_\_\_\_

Dr. Name Printed \_\_\_\_\_

Date \_\_\_\_\_