

EYE REPORT AND RECOMMENDATIONS

(Please Print On Hard Surface)

CHILD'S NAME: Last, First	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	OSIS #	DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP
SCHOOL	BOROUGH/DISTRICT		GRADE/CLASSROOM
PARENT/GUARDIAN	TELEPHONE #		

E12 History

	Yes	No	Unknown	
Newly identified case (1 ST E12S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of issue: _____
Follow up for previous issue of E12S not returned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	By: _____
Annual follow up for case with completed E12S	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Title: _____

TO THE PARENT: Your child did not pass one or more parts of the vision test. Please take your child to an eye doctor for an examination.

Screening Results: (to be filled out by DOHMH only)

Date of screening: _____ Team code: _____

FAR			NEAR	
Without Glasses	With Glasses		Without Glasses	With Glasses
20/	20/	Right	20/	20/
20/	20/	Left	20/	20/
20/	20/	Both	20/	20/

Right Eye (+1.50): Pass Fail Fusion: Pass Fail
 Left Eye (+1.50): Pass Fail Color Test: Pass Fail

TO THE DOCTOR: Please fill out all data fields below to permit proper educational planning for this child.

DOCTOR'S EXAMINATION: (to be filled out by medical staff only)

Date of examination: _____ Next visit: _____

Is any ocular pathology or any field limitation present? Yes No

If yes, describe: _____

	Uncorrected		Corrected	
	Distance	Near	Distance	Near
Right				
Left				
Both				

Prescription given:

	Sphere	Cylinder	Axis	Add
Right				
Left				

Diagnosis: _____

Special vision services recommended? Yes No If yes, specify: _____
 Color deficiency confirmed by doctor? Yes No

Your recommendations:

Are glasses to be worn? Yes No Indicate extent of use: For near For far Constant
 New prescription? Yes No
 Eyeglasses dispensed today? Yes No
 Patch prescribed? Yes No Which eye to be covered? Left Right
 Where worn? In school After school Both
 Hours per day? _____

Other treatment: _____

School accommodations:

Seating accommodation requested? Yes No
 Indicate the position: Front center Front left Front right
 Other accommodation: _____

Exclude from contact sports? Yes No If yes, until Temporary date: _____ Permanently
 Wear protective goggles in gym/sports? Yes No

Doctor's Name: _____ (First) _____ (Last) Specialty: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone #: (____) _____ License #: _____

For office use only Vendor: _____