

STUDENT VISION CARD

Student Name _____ Date _____

School _____ Town _____ Grade _____

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.**

The following organizations recommend the use of the Student Vision Card



Iowa Academy of Ophthalmology



To order more cards call 1-800-444-1772 • www.iowaoptometry.org

Visual Acuity

- Without correction
- With present correction
- With new correction

At Distance

- R20/ L20/
- R20/ L20/
- R20/ L20/

At Near

- R20/ L20/
- 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 _____