

Missouri Eye Examination Form for School

IDENTIFYING INFORMATION

Student Name: _____
 Date of Birth: _____
 Parent or Guardian Name: _____

CASE HISTORY

Date of Exam: _____
 Ocular History: Normal or Positive for: _____
 Medical History: Normal or Positive for: _____
 Drug Allergies: NKDA or Allergic to: _____
 Family Ocular and Medical History: Amblyopia Strabismus Glaucoma Diabetes
 Other: _____
 Other Pertinent Information: _____

EXAM

| | Normal | Abnormal | Not able to assess |
|---------------------|--------------------------|--------------------------|--------------------------|
| Amblyopia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Strabismus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Internal Eye Health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| External Eye Health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Visual Acuity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Binocular Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | OD | OS |
|--|-----------------|-----------------|
| Distance Unaided Acuity (20 ft) | 20 / _____ | 20 / _____ |
| Distance Best Corrected Acuity (20 ft) | 20 / _____ | 20 / _____ |
| Near Unaided Acuity (14 in) | 20 / _____ (eq) | 20 / _____ (eq) |
| Near Best Corrected Acuity (14 in) | 20 / _____ (eq) | 20 / _____ (eq) |

REFRACTION

| | | | | |
|--|----|---|---|---|
| | OD | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> |
| | OS | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> |

DIAGNOSIS:

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other: _____

Treatment Recommendations:

1 Glasses prescribed: YES NO

2 _____

3 _____

Spectacles to be worn for:

Constant wear Near vision only
 Distance vision only May be removed for recess/P.E.

PAYER:

Insurance Medicaid Complimentary Other form of payment

Examiner: _____

Date: _____

OD MD/DO