Sauk Prairie School District
207 Maple Street
Sauk City, WI 53583
Phone: 608-643-5509
Fax: 608-643-5503

School Nurse

KINDERGARTEN EYE EXAMINATION

Date of Exam: _____

Student Name: _____ School: _____ Homeroom: _____

Please complete this form. The information will become part of the student's school health records. Thank you.

	Distance	Near
Uncorrected	Visual Acuities	Visual Acuities
	Right 20/	Right 20/
	Left 20/	Left 20/
Corrected	Visual Acuities	Visual Acuities
	Right 20/	Right 20/
	Left 20/	Left 20/
Color Vision	___/6 OD	___/6 OS
Stereo	___/9	

OCULAR MOTILITY-SENSORY _____ PUPILS _____

GENERAL EYE HEALTH _____

_____

Should the child wear glasses? **YES** _____. **NO** _____.

If yes, when: **Constantly** _____ **Reading** Only _____.

For seeing **distance** ONLY _____.

Other _____.

Recommend Next Exam (Date): _____

_____

Examining Eye Doctor's Name (Please PRINT or TYPE): _____

Address: _____ Phone Number: _____

Examining Eye Doctor's Signature: _____

PLEASE RETURN TO: School Nurse, Sauk Prairie School District at the above address or fax number.