

KRS 156.160 (1) (g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no later than January 1 of the first year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Date of Birth: _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATION TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230

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: _____

Refraction with cycloplegic? (please indicate one) YES NO

| | OD | OS |
|-----------------------|------------|------------|
| Unaided Acuity | 20 / _____ | 20 / _____ |
| Best Corrected Acuity | 20 / _____ | 20 / _____ |

Normal Abnormal Not able to Assess

| | | | |
|--|--------------------------|--------------------------|--------------------------|
| External Exam (eye and adnexa) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Internal Exam (media, lens, fundus, etc) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological Integrity (pupils) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Binocular Function (stereopsis) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Accommodation and convergence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Color Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Diagnosis: Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: YES NO

2 _____

3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

- Educate (parents/patients) about eye/vision disorders and needed vision care
- Counsel (parents/patients) regarding eye safety
- Stress importance of early, preventative eye care
- Recommend re-examination, as appropriate

Signed: _____ Date: _____
Optometrist/Ophthalmologist

Address: _____ Telephone: () _____