

**EYE EXAMINATION REPORT**

**Concordia Learning Center at St. Joseph's School for the Blind**  
**761 Summit Avenue**  
**Jersey City, New Jersey 07307-3831**  
**(201) 876-5432 / Fax (201) 876-5430**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Parent's/Guardian's Name(s) \_\_\_\_\_  
 Parent's/Guardian's E-mail: \_\_\_\_\_  
**Diagnosis of eye condition (Primary Cause of visual impairment)** \_\_\_\_\_  
 Age of Onset \_\_\_\_\_ History \_\_\_\_\_

**Visual Acuity**

*If the acuity cannot be measured, complete this box using Snellen Acuties or Snellen Equivalentents or NLP, LP, HM, CF.*

Without Glasses		With Best Correction	
Near	Distance	Near	Distance
R	R	R	R
L	L	L	L

**Please check the appropriate estimate of visual functioning.**

Total Blindness  Legal Blindness ( 20/200 with correction)  20/70 o.u. with correction  Field loss of 20 degrees or more o.u.

**Visual Fields** Visual Field R [ ] in degrees Visual Field L [ ] in degrees

**Color Vision** [ ] Normal [ ] Abnormal **Photophobia** [ ] Yes [ ] No

**Is the present eye condition:** [ ] Permanent [ ] Recurrent [ ] Improving [ ] EOG [ ] VER  
 [ ] Progressive [ ] Communicable [ ] Can be improved [ ] ERG [ ] Visual Fields

**Has the student had eye surgery?** Yes \_\_\_ No \_\_\_ If yes, circle what type of surgery : 1) Cataract 2) Cornea 3) Retinal 4) Enucleation 5)Other

**Has any eye medication been prescribed?** Yes \_\_\_ No \_\_\_ If yes, state type, dosage

**Low Vision aids prescribed** Glasses [ ] Sunglasses [ ] Monocular [ ] Other \_\_\_\_\_

**Are there any physical restrictions or limitations in participating in school activities?**

Yes \_\_\_ No \_\_\_ If yes, Explain \_\_\_\_\_

**Type of examination** [ ] Initial visit [ ] six month evaluation [ ] yearly update  
**Reexamination needed in** [ ] 1 year [ ] 2 year [ ] 3 Years

\_\_\_\_\_  
*Print or Type name of Licensed Ophthalmologist*

\_\_\_\_\_  
*Signature of Licensed Ophthalmologist*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*Date of Examination:*

\_\_\_\_\_  
*City State Zip*

\_\_\_\_\_  
*Telephone Number:*

*Release of Information Parent Signature:* \_\_\_\_\_