

STUDENT VISION CARD

Student Name _____ Date _____

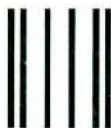
School _____ Town _____ Grade _____

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



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



NO POSTAGE
NECESSARY IF
MAILED IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 107 DES MOINES, IA

POSTAGE WILL BE PAID BY ADDRESSEE



IOWA OPTOMETRIC ASSOCIATION
6150 VILLAGE VIEW DRIVE STE 105
WEST DES MOINES IA 50266-9962

Visual Acuity

<input type="checkbox"/> Without correction	R20/	L20/	R20/	L20/
<input type="checkbox"/> With present correction	R20/	L20/	R20/	L20/
<input type="checkbox"/> With new correction	R20/	L20/	R20/	L20/

At Distance**At Near****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 _____

Eye Care Professional:

Please complete this postage paid portion of the Student Vision Card, detach and drop in the mail. This information will be used for data collection purposes only. Thank you!

Patient Grade _____ **School** _____ **Town** _____

Patients first visit to an eye doctor?

☐ Yes ☐ No

Vision Correction Recommended?

☐ Yes ☐ No

Eye Health

Please indicate if present

☐ Amblyopia ☐ Strabismus

☐ Refractive error ☐ Other _____
(greater than +/-1.25)

Thank you!