RED MOUNTAIN
FAMILY SERVICES, INC.

Vision Exam Report Form

Name of Facility:	
Address:	City/ State:

Client: ______________________ Date of Birth: ______________________

Visual Acuity:

Right eye with glasses: ______________________ Right eye without glasses: ______________________

Left eye with glasses: ______________________ Left eye without glasses: ______________________

Alignment:

°Straight: ____________ Tropia: ____________ Phoria: ____________

Diagnosis: ______________________ Prescription: ______________________

________No Further evaluation is necessary at this time

________Follow-up is recommended in Month(s) ____________ Year(s) ________

The Following educational considerations are recommended:

- ☐ Preferential seating in classroom: Where: ______________________
- ☐ Glasses to be worn at all times
- ☐ Glasses to be worn part time, primarily for: Reading ____________ Distance: ____________
- ☐ Full participation in Physical Education Classes
- ☐ Restricted Physical Education

Restrictions: ______________________

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- ☐ Other: ______________________

______________________ ______________________

Signature Name (PRINT)

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Date of Exam:

Official Property of Red Mountain Family Services, Inc.