Name of student ____DOB ______ Age ______
Grade__________ School ____
Parent Name ____ Date of exam ___________________

Please complete every blank of this form!

Visual Acuity (*mark all that apply*)

	Distance		**Near**	
Without Rx:	(R) 20/______	(L) 20/_____	(R) 20/______	(L) 20/_____
With old Rx:	(R) 20/______	(L) 20/_____	(R) 20/______	(L) 20/_____

Old Rx OD: _____________________ No Rx† 1
OS: ______________________

Cover Test
Distance: ___________________
Near: ___________________

Correction worn (*check one*)
No Rx† 1
Old Rx† 2
New Rx† 3

Color Perception (*males only*)
Normal† 1
Deficient† 2

Refraction
OD: _______________________ 20/_____
OS: _______________________ 20/_____

(*check one*) Cycloplegic† 1
Non-cycloplegic† 2

Final Prescription
OD: ________________________________
OS: ________________________________
Add: _____________

Diagnoses (*mark all that apply*)
† 1 Amblyopia
† 2 Strabismus
† 3 Convergence problems
† 4 Accommodation problems
† 5 Ocular health: ____
† 6 Other: ____
† 7 Other: ____
† 8 Other: ____

Exam was paid by
† 1 Private Pay
† 2 Medical Insurance
† 3 Vision Insurance
† 4 Lions Club
† 5 Free Exam by Doctor
† 6 Other: ____

Name of student ____DOB ______ Age ______
Grade___________ School ____
Parent Name ____ Date of exam ___________________

Recommended Treatment

- † No treatment indicated
- † Present corrective lenses are satisfactory
- † New corrective lenses have been recommended and should be worn:
  - † Constantly
  - † Classroom
  - † Near only
  - † Distance only
  - † Sports
  - † Computer
- † A program of amblyopia treatment has been implemented
  - † Eye drops, so the *(circle one)* R / L pupil will be dilated all of the time
  - † Eye patch should be worn on the *(circle one)* R / L eye; how often? ______________________
  - † Other ____
- † Return to this office on _________________ (*date*) for
  - † Prescription check
  - † Vision therapy
  - † Amblyopia therapy
  - † Other ____
- † Refer to another doctor for
  - † Ocular health
  - † Vision therapy
  - † Amblyopia therapy
  - † Other ____

Additional special recommendations for classroom interaction

____
____
____
____
____

Signature ____(O.D.) (D.O.) (M.D.)
Print Name ____
Practice Name ____
Address ____
City, State Zip ____
Phone Number _____________________________________ Fax Number ___________________________

HIPAA Information Release Form

As parent or guardian of the student named above, I authorize the eye care provider listed to disclose (by mail or by facsimile) the results of the HB 95 Eye Exam Report for IEP to my child's school:

Name of School ________________________________ Attention ________________________________
Address ____
City ____________________________ State ________ Zip__________
Telephone ____________________________
Fax ____________________________

The purpose of disclosing the Eye Exam Report is for use in connection with my child's Individualized Education Program (IEP).

I understand that authorized persons associated with my child's school (or school system) may have access to, and use of, the Eye Exam Report for the purpose described above.

I understand that while in possession of authorized school personnel, the Eye Exam Report is not covered by HIPAA. Instead, it is an "education record," whose privacy, use and disclosure is protected by the Family Educational Rights and Privacy Act ("FERPA").

I understand that my refusal to sign this Authorization will not affect my child's ability to obtain treatment from the eye care provider listed above.

I understand my right to inspect or copy information disclosed by this Authorization.

I understand I may revoke (cancel) this Authorization at any time. Revocation must be in writing. The eye care provider cannot be held responsible for having disclosed information in reliance of this Authorization before receiving a written revocation.

I release the eye care provider from legal liability for disclosing The Eye Exam Report (and Protected Health Information contained in it) as authorized by my signature below.

This Authorization will expire on:

Date ____________________ or
Event ____________________

____
Signature of Parent or Guardian

____
Print Name

Date ____________________