STEEL VALLEY SCHOOL DISTRICT
SCHOOL VISION EVALUATION REPORT

Documentation of a vision screening and exam is required for all incoming kindergarten students. This can be done by either you PCP or eye doctor and must be completed within the last 12 months.

Name:_____ **Date of Birth:**_____

School: _____ **Date:** _____ **Grade:** _____

REQUIRED TESTS*	Pass	Fail	Recommend Further Evaluation *(comments noted below)*
Amblyopia	_____	_____	_____
Strabismus	_____	_____	_____
Internal Eye Health	_____	_____	_____
External Eye Health	_____	_____	_____
Visual Acuity			
Right eye @ distance (20 ft.):		20/____	aided/unaided
Left eye @ distance (20 ft.):		20/____	aided/unaided
Right eye @ near (16 in.):		20/____	aided/unaided
Left eye @ near (16 in.):		20/____	aided/unaided

ADDITIONAL TESTS	Pass	Fail	Recommend Further Evaluation	Did Not Test
Eye Alignment at Distance	_____	_____	_____	_____
Eye Alignment at Near	_____	_____	_____	_____
Depth Perception	_____	_____	_____	_____
Color Vision	_____	_____	_____	_____
Focusing Amount	_____	_____	_____	_____
Focusing Flexibility	_____	_____	_____	_____
Focusing Lag (Accuracy)	_____	_____	_____	_____
Convergence (Crossing) Ability	_____	_____	_____	_____
Saccade (Rapid) Eye Movement	_____	_____	_____	_____
Pursuit (Tracking) Eye Movement	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

COMMENTS/RECOMMENDATIONS: _____

_____

_____

Evaluation performed by: _____ ___ O.D. ___ M.D. ___ P.A. ___ A.P.R.N.
(signature)

Office Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ **Date:** _____