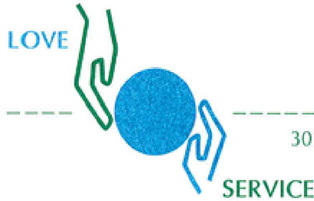

Cleary School for the Deaf

301 Smithtown Boulevard, Nesconset, New York 11767-2077
www.clearyschool.org
631-588-0530 (V & TTY)
631-588-0016 FAX

VISION FORM

Student: ______________________ **DOB:** ________________

Report of Eye Specialist

Diagnosis: Right eye __________ Left eye ______________ Both___________

Additional Medical Diagnosis: _____________________________________

Healthy eyes: Yes __________ No __________

Visual Acuity:

	Uncorrected		**Corrected**	
	Near	Far	Near	Far
Right (OD)				
Left (OS)				
Both (OU)				

*****Peripheral Vision:** ____

Does student require glasses? ❒yes ❒no *New Prescription? ❒yes ❒no

Prescription given: ____

Under what conditions should glasses be worn? (Check all that apply): ❒ near ❒ distance ❒full-time

School accommodations requested:

Special vision services recommended? ❒ yes ❒ no If yes, describe: __________________

Seating accommodation requested: ❒ yes ❒ no

❒ Any front seat ❒ Blackboard ❒ Front Left ❒ Front Center ❒ Front Right

Should physical activities be limited because of eye condition ❒ yes ❒ no

If yes, explain ____

Examiner's Name/Title and Signature ________________________________

Facility Name and Address: ____________________________________

Phone Number: ______________________________

Date of Exam: __________________________ **PB20**