North Adams Community Schools

625 Stadium Dr.
Decatur, IN 46733

Excellence: Teach it, Model it, Inspire it, Achieve it!

KINDERGARTEN VISION EXAMINATION

The state requires that a modified eye exam be done prior to your child entering kindergarten

Name _____ Date of Birth _____

Address _____ Date _____

1. History (description of past vision and eye health problems plus present observations or complaints relative to vision)

_____

2. Visual Acuity (with/without) Glasses R20/_____ L20/_____

3. Cover Test

	Distance (20 ft)	Near (16”)
Esotropia (any)	_____	_____
Exotropia (any)	_____	_____
Esophoria (5 PD or more)	_____	_____
Exophoria (5 PD or more)	_____	_____
Hyperphoria (2 PD or more)	_____	_____

4. Refractive Error

Hyperopia	R_____ L_____	Is it +1.50 DS or more?	R_____	L_____
Myopia	R_____ L_____	Is it -0.50 DS or more?	R_____	L_____
Astigmatism	R_____ L_____	Is it = 1 DC or more?	R_____	L_____
Anisometropia		Is it = 1 DC or more?	_____	
		Is it = 1 DS or more?	_____	

5. Organic (Pathology of eye and /adnexa)_____

_____

6. Color Vision Pass☐ Fail☐

7. If corrective lenses are prescribed, they are for? **No Rx at present** _____

Constant Wear☐ Near Vision Only☐ Other_____

8. Corrected Visual Acuity (if corrective lenses prescribed)

R_____ L_____

9. Special Comments and Recommendations_____

_____

10. Re-examination Advised In

Six (6) months_____ Twelve (12) months_____ Other_____

Doctor Signature _____ Date _____

TO PARENTS: THIS FORM IS TO BE COMPLETED BY YOUR PHYSICIAN AND RETURNED TO THE SCHOOL NURSE.