

LOS ANGELES UNIFIED SCHOOL DISTRICT  
**VISUALLY IMPAIRED PROGRAM**  
610 Micheltorena Street  
Los Angeles, CA 90026  
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**FAX TO:** Mervin Rivera, RN, BSN, PHN, CSN

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**STUDENT EYE REPORT**

NAME: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ GR: \_\_\_\_\_ SEX: \_\_\_\_\_

MEDICAL RECORD #: \_\_\_\_\_ DATE OF EXAMINATION: \_\_\_\_\_

DIAGNOSIS: O.D. \_\_\_\_\_ O.S. \_\_\_\_\_

**DISTANCE VISUAL ACUITY**

**NEAR VISION ACUITY**

WITHOUT CORRECTION	WITH BEST CORRECTION	WITHOUT CORRECTION	WITH BEST CORRECTION
O . D . _____	O . D . _____	O . D . _____	O . D . _____
O . S . _____	O . S . _____	O . S . _____	O . S . _____
O . U . _____	O . U . _____	O . U . _____	O . U . _____

**FIELD VISION**

LIMITATIONS YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, WIDEST DIAMETER IN DEGREES OF REMAINING FIELD O.D. \_\_\_\_\_ O.S. \_\_\_\_\_

**PROGNOSIS AND RECOMMENDATIONS**

IMPAIRMENT IS: \_\_\_\_\_ STABLE \_\_\_\_\_ DETERIORATING \_\_\_\_\_ ABLE TO IMPROVE

OTHER \_\_\_\_\_

IF GLASSES ARE PRESCRIBED: \_\_\_\_\_ TO BE WORN CONSTANTLY \_\_\_\_\_ CLOSE WORK ONLY

OTHER RECOMMENDATIONS \_\_\_\_\_

ARE CONTACTS PRESCRIBED? \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ DUAL USE WITH GLASSES

LOW VISION AID PRESCRIBED? \_\_\_\_\_ YES \_\_\_\_\_ NO IF YES, WHAT TYPE \_\_\_\_\_

PHYSICAL ACTIVITY: \_\_\_\_\_ RESTRICTIONS: \_\_\_\_\_ YES \_\_\_\_\_ NO

RECOMMENDATIONS: \_\_\_\_\_

**DOCTOR INFORMATION:** NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME OF HOSPITAL/CLINIC \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

Please take this form to appointment with the eye specialist and return it to Mervin Rivera when completed. Thank you.  
Por favor, lleve esta hoja al cita con especialista de los ojos y devuélvela a Mervin Rivera cuando está completo. Gracias.