LOS ANGELES UNIFIED SCHOOL DISTRICT
VISUALLY IMPAIRED PROGRAM
610 Micheltorena Street
Los Angeles, CA 90026
PH: (323) 669 -4363 | FAX: (323) 669 -4366
E-Mail: VIMedicalRecords@lausd.net

STUDENT EYE REPORT

NAME _____ D.O.B._____ GR:_____ Gender: _____

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 email to VIMedicalRecords@lausd.net when completed. Thank you.
Por favor, lleve esta hoja al cita con especialista de los ojos y envíela por correo electrónico a VIMedicalRecords@lausd.net cuando está completo. Gracias.