

KENTUCKY EYE EXAMINATION FORM FOR SCHOOL ENTRY

KRS 156.160.8 (g) requires proof of a vision examination by an optometrist or ophthalmologist. This proof shall be submitted to the school no later than January 1 of the first year that a child is enrolled in a Kentucky public school, public preschool, or Head Start.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: _____

Social Security Number: _____ Date of Birth: _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATION TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230

CASE HISTORY

Date of Exam: _____

Chief Complaint: _____

Ocular History: Normal or Positive for: _____

Medical History: Normal or Positive for: _____

Drug Allergies: NKDA or Allergic to: _____

Family Ocular and Medical History: Amblyopia Strabismus Glaucoma Diabetes

Other: _____

Other Pertinent Information: _____

Refraction with cycloplegic? (please indicate one) YES NO

	OD		OS	
Unaided Acuity	20 / _____	20 / _____	20 / _____	20 / _____
Best Corrected Acuity	20 / _____	20 / _____	20 / _____	20 / _____

	Normal	Abnormal	Not able to Assess
External Exam (eye and adnexa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internal Exam (media, lens, fundus, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Integrity (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Binocular Function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accommodation and convergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diagnosis: Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other: _____

Recommendations:

1 Glasses prescribed: YES NO

2 _____

3 _____

Age appropriate and suggested anticipatory guidance (health assessments):

- Educate (parents/patients) about eye/vision disorders and needed vision care
- Counsel (parents/patients) regarding eye safety
- Stress importance of early, preventative eye care
- Recommend re-examination, as appropriate

Signed: _____ Date: _____
Optometrist/Ophthalmologist

Address: _____ Telephone: _____