Vision Exam Guide for School Teams

Please complete form

Child's: Last name	First Name	Age
Doctor's Name:		Date of Exam:
School Personnel/ Position:		

Have you noticed any new or unusual visual behaviours at school? If so, describe:

What are your questions for the doctor?

What are your questions about the student's glasses / contact lenses?

Is there more information about the eye condition?

Additional Notes for the Doctor: