

# STUDENT VISION CARD

Student Name \_\_\_\_\_ Date \_\_\_\_\_

School \_\_\_\_\_ Town \_\_\_\_\_ Grade \_\_\_\_\_

**TO THE PARENT OR GUARDIAN:** To fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. Good vision directly contributes to a child's ability to learn while in school. As a part of your back-to-school preparations, it is recommended that you take your child and this card to your family eye doctor for a complete eye health examination. **This card should be signed by the eye care professional and returned to the school nurse or teacher by your child.**

The following organizations recommend the use of the Student Vision Card



To order more cards call 1-800-444-1772 • [www.iowaoptometry.org](http://www.iowaoptometry.org)

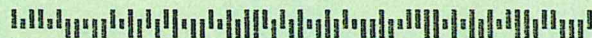


NO POSTAGE  
NECESSARY IF  
MAILED IN THE  
UNITED STATES

**BUSINESS REPLY MAIL**

FIRST-CLASS MAIL PERMIT NO.107 DES MOINES, IA

POSTAGE WILL BE PAID BY ADDRESSEE



IOWA OPTOMETRIC ASSOCIATION  
6150 VILLAGE VIEW DRIVE STE 105  
WEST DES MOINES IA 50266-9962

**Visual Acuity**

<input type="checkbox"/> Without correction	R20/	L20/	R20/	L20/
<input type="checkbox"/> With present correction	R20/	L20/	R20/	L20/
<input type="checkbox"/> With new correction	R20/	L20/	R20/	L20/

**External Eye Health**
 Normal       Other
**Internal Eye Health**
 Normal       Other
**Vision Analysis**

<b>R</b>	<b>L</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Normal eyesight	<input type="checkbox"/> Eye teaming difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Nearsighted (myopia)	<input type="checkbox"/> Crossed-eyes (strabismus)
<input type="checkbox"/>	<input type="checkbox"/>	Farsighted (hyperopia)	<input type="checkbox"/> Eye focusing difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Astigmatism	<input type="checkbox"/> Sensitivity to light
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia	
<input type="checkbox"/> Other		_____	

**Vision Correction Recommendations**

<input type="checkbox"/> No correction necessary	To be worn for:	
<input type="checkbox"/> No change in present prescription	<input type="checkbox"/> Constant wear	<input type="checkbox"/> Near vision only
<input type="checkbox"/> New prescription needed	<input type="checkbox"/> Distance vision only	<input type="checkbox"/> As needed

**TO THE EYE CARE PROFESSIONAL:** Please sign and date this card after examination.

Dr. Name: (Please Print) \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

**Eye Care Professional:**

Please complete this postage paid portion of the Student Vision Card, detach and drop in the mail. This information will be used for data collection purposes only. Thank you!

**Patient Grade** \_\_\_\_\_ **School** \_\_\_\_\_ **Town** \_\_\_\_\_

**Patients first visit to an eye doctor?**

Yes     No

**Vision Correction Recommended?**

Yes     No

**Eye Health**

*Please indicate if present*

Amblyopia     Strabismus

Refractive error     Other \_\_\_\_\_  
(greater than +/-1.25)

*Thank you!*