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

IDPH Iowa Department of Public Health

IOWA OPTOMETRIC ASSOCIATION

Iowa PTA everychild.onevoice.

Prevent Blindness Iowa

To order more cards call 1-800-444-1772 • 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	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health
☐ Normal ☐ Other

Internal Eye Health
☐ Normal ☐ Other

Vision Analysis

R	L		
☐	☐	Normal eyesight	☐ Eye teaming difficulty
☐	☐	Nearsighted (myopia)	☐ Crossed-eyes (strabismus)
☐	☐	Farsighted (hyperopia)	☐ Eye focusing difficulty
☐	☐	Astigmatism	☐ Sensitivity to light
☐	☐	Amblyopia	

☐ Other _____

Vision Correction Recommendations
☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

To be worn for:
☐ Constant wear ☐ Near vision only
☐ Distance vision only ☐ 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!