

# 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 / _____
Best Corrected Acuity	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: ( ) \_\_\_\_\_