# 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) | ☐ | ☐ | ☐ |
| Internal Exam (media, lens, fundus, etc) | ☐ | ☐ | ☐ |
| Neurological Integrity (pupils) | ☐ | ☐ | ☐ |
| Binocular Function (stereopsis) | ☐ | ☐ | ☐ |
| Accommodation and convergence | ☐ | ☐ | ☐ |
| Color Vision | ☐ | ☐ | ☐ |

**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: ( )_____