VISION ACTION PLAN

TO BE FILLED OUT BY THE EYE DOCTOR AND RETURNED TO THE SCHOOL NURSE OR HEALTH MANAGER

This form was completed (MM/DD/YYYY): _____ A follow-up eye exam is needed (MM/YYYY): _____

Please update the Vision Action Plan annually or when the treatment plan changes. This Plan is designed for use at home and school, and also as a supplement to eye exam results provided to the primary care provider. Its goal is to facilitate support of the treatment plan.

Student Name: _____ Date of Birth: _____

School (Name/Address/Fax): _____

Primary Care Provider (Name/Address/Fax): _____

Date of eye exam (MM/DD/YYYY): _____

Eye doctor (Name/Practice/Phone/Fax): _____

Office or store where eyeglasses were obtained (if known): _____

CURRENT DIAGNOSIS: _____

BEST VISUAL ACUITY (circle one: with eyeglasses without eyeglasses)

Right Eye - _____ Left Eye - _____ Both Eyes - _____

CURRENT TREATMENT PLAN:

☐ Eyeglasses are not needed at this time

☐ Eyeglasses should be worn:

- ☐ All of the time when awake
- ☐ Only when the child needs to see clearly at distance
- ☐ Only when the child needs to see clearly up close

☐ An eye patch should be worn:

- ☐ To cover right eye ☐ To cover left eye
- ☐ Total of ____ hours per day (____ hours at home, ____ hours at school)

*If the child has been prescribed eyeglasses, eyeglasses should be worn when they wear the patch.

☐ Eye drops will be used instead of a patch and will be given by _____. These eye drops will cause the pupil to get larger and the vision to blur in the better-seeing eye.

☐ Other: _____

ADDITIONAL NOTES AND RECOMMENDATIONS:

_____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for this completed form to be sent to the school nurse or health manager at my child's school and for s/he to share the information with my child's teacher and other school professionals who are directly involved with my child. Also, I give permission for this completed form to be send to my child's primary care provider.

Parent/Guardian Signature: _____ Date: _____