

EYE REPORT
The Maryland School for the Blind

The examination and form must be performed by an eye care professional. This report must be based on an examination that was done within the past year.

Return this completed form to: Community Liaison
Maryland School for the Blind
3501 Taylor Avenue
Baltimore, MD 21236
Office: 410-444-5000, ext. 726
FAX: 410-319-5708

CHILD'S NAME: _____ DATE OF BIRTH: _____

Ophthalmologic Diagnosis/Etiology: _____

Prognosis: Is vision: ___ Stable ___ Unstable ___ Undetermined

VISUAL ACUITY

DISTANCE VISION		NEAR VISION	
<u>Without Correction</u>	<u>With correction</u>	<u>Without Correction</u>	<u>With Correction</u>
O.D. _____	_____	_____	_____
O.S. _____	_____	_____	_____
O.U. _____	_____	_____	_____

Does this child wear: ___ Corrective glasses ___ Safety glasses ___ Prosthesis(es)

Eyeglasses Prescription: Date prescribed: _____
O.D.: ___ sph ___ cyl ___ axis ___ add
O.S.: ___ sph ___ cyl ___ axis ___ add

Does this child have a visual field limitation: ___ Yes ___ No
If yes, is the remaining visual field less than or equal to 20 degrees: _____

If measurement is not possible, please estimate acuity: _____

Does this child have a visual impairment: _____

In your opinion, is this child legally blind (best corrected acuity $\leq 20/200$ or visual field $< = 20$ degrees) ___ Yes ___ No

In your opinion, is this child considered partially sighted (best corrected acuity between 20/70 - 20/100) ___ Yes ___ No

(PLEASE CONTINUE ON REVERSE SIDE)

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Page 2

Is this child restricted from adapted physical education activities (MSB does not consider poor visual acuity to be a restricting factor), such as swimming or wrestling, due to his/her visual diagnosis/prognosis: Yes No

If YES, please explain: _____

This child should wear protective eyewear:

At ALL times: Yes No

During PE class/sports activities: Yes No

Not ever needed: Yes No

If YES, please explain: _____

Date of Examination

Follow-up Date

PRINTED Examiner Name

Degree:

Examiner Signature

Date Signed

Office Address: _____
Street

City, State, Zip Code

Office Phone Number: _____

- Please attach a report that includes the following:
1. Related systemic medical problem.
 2. On-going treatment.
 3. Past treatment or surgery.
 4. Planned treatment or surgery.