OUR LADY of MOUNT CARMEL
CATHOLIC SCHOOL

STUDENT VISION SCREENING FORM

NEEDS TO BE PERFORMED BY AN OPTOMERTRIST OR AN OPTHALMOLOGIST
TO SATISY THE STATE HEALTH MANDATE
REQUIREMENT FOR KINDERGARTEN ADMISSION TO OLMC

NAME_____ **DATE**_____

OBSERVATIONS OR COMPLAINTS RELATIVE TO VISION_____

_____

SCREENED WITH GLASSES YES_____ **NO**_____

1. **VISION DISTANCE R**_____ **L**_____ **VISION NEAR R**_____ **L**_____
2. **COVER TEST PASS**_____ **FAIL**_____
3. **STEREOPSIS PASS**_____ **FAIL**_____
4. **RETINOSCOPY PASS**_____ **FAIL**_____
5. **OCULAR HEALTH EXTERNAL PASS**_____ **FAIL**_____

   INTERNAL PASS_____ **FAIL**_____

COLOR DEFINCIENCY NO_____ **YES**_____ **TYPE**_____

ADDITIONAL REMARKS:_____

_____

RESULTS OF VISION TEST: (CIRCLE ONE) PASS BORDERLINE FAIL

RECOMMENDATIONS/TREATMNET_____

_____

DOCTOR'S NAME: (PRINT) _____**PHONE NUMBER**_____

DOCTOR'S SIGNATURE_____

THIS FORM NEEDS TO BE RETURNED BY AUGUST 1st

14596 Oakridge Road, Carmel, IN 46032 † Phone: (317) 846-1118 † FAX: (317) 582-2375