



VISION REPORT CARD

Child's Name _____ Grade _____

The following behaviors have been observed in your child, which could indicate a vision or other health problem that may affect your child's academic performance.

- Loses place frequently when reading
- Short attention span or daydreaming
- Re-reads or skips lines unknowingly when reading
- Uses finger as a guide when reading
- Avoids close work
- Complains of frequent headaches
- A drop in scholastic or sports performance
- Covers one eye
- Tilts the head (when reading)
- Squints one or both eyes
- Places head close to book or desk when reading or writing
- Has difficulty remembering, identifying and reproducing basic geometric forms
- Poor eye-hand coordination skills

Pursuant to KSA 72-5205, you are encouraged to seek a comprehensive vision examination from an optometrist or ophthalmologist for your child to rule out any vision problems that may be affecting your child's ability to learn. Please take this form with you to your optometrist or ophthalmologist at the time of your child's vision examination. If it is not covered by Medicaid, HealthWave or private insurance, the cost of the vision examination will be the responsibility of the child's parent or guardian. **We request that you or the doctor return a copy of this form to the school at the completion of the examination.**

School Official _____ Date _____

Phone Number _____

For completion by an optometrist or ophthalmologist only.

COMPREHENSIVE VISION EXAMINATION REPORT

Patient _____ Date of Birth _____

Name of Parent or Guardian _____ Date of Examination _____

Address _____ Phone _____

City _____ State _____ Zip _____

- Normal eye health and no need for vision correction.
- Treatment for a visual condition has been prescribed or recommended.
 - Eyewear was prescribed Other treatment recommended _____
- The condition(s) found during the examination were: _____

Name of optometrist/ophthalmologist (Please Print)

Signature of optometrist/ophthalmologist