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VISION EVALUATION FOR TEEN SUMMER CAMP

(To be completed by an Eye Care Professional)

Applicant Name _____

Date of Last Exam _____ Date of Next Appointment _____

Cause of Vision Loss _____

Is Applicant Legally Blind? ☐ **Yes** ☐ **No** Comment _____

Visual Acuities: OD _____ OS _____ OU _____

With Correction: OD _____ OS _____ OU _____

Near Vision: OD _____ OS _____ OU _____

Central Fields: OD _____ OS _____ OU _____

Peripheral Fields: OD _____ OS _____ OU _____

If available, please attach copies of visual field results

Ocular Medications: _____

Does applicant have functional low vision? _____

Fixation: _____

Scanning: _____

Does patient use low vision aides to travel? _____

Comments _____

Signature _____, M.D./D.O./O.D. Address _____

Name (print) _____ City _____

Telephone _____ State _____ Zip _____

Date _____