Overbrook School for the Blind
6333 Malvern Avenue
Philadelphia, PA 19151
Phone: 215-877-0313 x 231

EYE EXAMINATION REPORT

PLEASE COMPLETE THE LOWER PART OF THIS FORM AND RETURN IT FOR RECORD PURPOSES. THANK YOU.

Student's Name: _____

Date of Birth: _____

Date of Exam: _____

Eye Doctor's Name: _____

Address: _____

Phone #: _____

Purpose of Visit: _____

Pertient finding/treatment. Please include ---

Visual Acuity: Right Eye _____ Left Eye _____ Both Eyes _____

Correction: _____ Visual Fields: _____

Diagnosis: _____

Medication - including dosage and times to be given: _____

_____

Recommendations and instructions: _____

_____

_____
Physician Name (please print)

_____
Date form completed

Office Address: _____

_____

_____

_____

_____
Office Phone Number

_____
Physician Signature