Area Five Agency Head Start
1801 Smith Street
Logansport, IN 46947
(574)722-4451 Fax (574)722-3447

Eye Exam Form

Dear Eye Care Provider,
This patient attends a Head Start program. Head Start is required to ensure that each child is up-to-date on a schedule of well-child care. You have received this form for the following reason:
_____The child's parent reports that the child has been under your care. Please complete this form for the child's most recent eye exam, and indicate when the child should return for care.
_____The child has failed a vision screen at Head Start, and has been referred to you for a complete eye exam.

PLEASE BE SURE THIS FORM IS COMPLETELY FILLED OUT BY THE EXAMINING EYE DOCTOR and return by fax 574-722-3447 or mail to Area Five Agency Head Start, 1801 Smith St., Logansport, IN 46947. Questions may be directed to Area Five Agency Head Start's Child Health and Nutrition Manager, Stormy Fiscel, RN at 574-722-4451 ext 272.

Child's name:_____ Date of Birth:_____

Eye Care Provider Name (print):_____
Eye Care Provider Phone:_____

Date of Exam:_____

Visual Acuity: OD:_____ OS:_____ Anisocoria: yes / no

Method of testing vision (circle all that apply)
a. Snellen letters b. Allen figures c. HOTV d. E-game/broken circle
e. CSM/F & F f. Other:_____

Method of Assessing Alignment (circle all that apply): Penlight Exam Cross-Cover Testing
Ocular Alignment: Ortho:_____ Strabismus:_____

Cycloplegic Refraction: Agent (circle one): Cyclogyl 1% Cyclogyl 2% Mydriacyl 1% None
OD:_____ _____X _____
OS:_____ _____X _____

Diagnosis of Amblyopia: Yes No
Amblyogenic Factors: Strabismus:_____ Anisometropia:_____ Media Opacity:_____ Other:_____

Treatment: None:_____ Glasses:_____ Other(specify):_____

Follow-up: None:_____ Yes:_____ If yes, specify date/reason: _____

Signature of Eye Care Provider:_____**Date:**_____

AFTER COMPLETION, YOU MAY FAX THIS FORM DIRECTLY TO HEAD START AT: (574)722-3447.