

## **McFarland School District**

5101 Farwell Street • McFarland, WI 53558-9216 • (608) 838-3169

District Administrator: Aaron Tarnutzer

## **Report of Eye Examination**

Dear Provider:

In order to evaluate the effectiveness of this program, we are asking you to complete this form and return it to the McFarland School District Health Office address or fax number listed below. As always, your feedback is greatly appreciated!

gave	(Child's Name)			iii eye exaiii oii			Date)		
	(Ciliu's Naille)						,		
/ISUAL ACUITY:	Uncorrected	Right	20/		Left	20/			
	Corrected	Right	20/ 20/		Left	20/ 20/			
DIAGNOSIS (check one):	Normal		н	STORY (check one):	:N	ew vision p	oroblem		
REFRACTIVE ERROR:	Amblyopia			,		Previously diagnosed prob			n
	Muscle In	nbalance							
	Nearsightedness		FOLLOW-UP APPOINTMENT (6-12 months):						
	Farsightedness Astigmatism		· -						-
			Other:						
REATMENT:	1 <sup>st</sup> lenses	prescribed	I						
	Updated lenses prescribed								
	Other						_		
OMMENTS:									
									_
									_
HYSICIAN'S NAME:									
HONE:									
HONE: IGNATURE:									
HONE: IGNATURE:									
HONE: IGNATURE: ATE:							  fro	m	
HONE: IGNATURE: ATE:							fro	m	
HONE: IGNATURE: ATE:	elease of medical	information		(Chil			fro	m	
HONE: IGNATURE: ATE:	elease of medical	information	on for	(Chil			fro	m	
PHYSICIAN'S NAME:PHONE: PHONE: BIGNATURE: DATE: RELEASE: I consent to the r	elease of medical (Doctor or Clinic)	information	on for	(Chil				m	-
PHONE:	elease of medical  (Doctor or Clinic)	information to N	on for McFarland School (City, State, Zip)	(Chil				m	_
PHONE: GIGNATURE: DATE: CHARGE I consent to the resolution (Address) This release is in effect for the resolution of the resolution (Address)	elease of medical  (Doctor or Clinic)	information to N	on for McFarland School (City, State, Zip)	(Chil		(Phone)		m	-
PHONE:	elease of medical  (Doctor or Clinic)  one year from the	information to N	on for McFarland School (City, State, Zip)	(Chil		(Phone)		m	-
HONE:	elease of medical  (Doctor or Clinic)  One year from the Guardian Signature)	information to N	on for McFarland School (City, State, Zip)	(Chil	d's Name)	(Phone)			- Health Office
CHONE:  CIGNATURE:  CHONE:  CH	elease of medical  (Doctor or Clinic)  Done year from the suardian Signature)	information to N	on for McFarland School (City, State, Zip) Ny signature.	(Chill District.	d's Name)	(Phone)		<b>MHS</b> Phone	Health Office :: 608-838-468: 608-838-4562

(608) 838-3146