

VISION CLEARANCE

SPORT: _____

School _____ Name _____

Grade _____ Address _____

To Parent or Guardian:

A recent vision appraisal of your child warrants more complete information prior to approval of his/her participation in the sports program.

_____ Date

_____ School Nurse

To Examiner:

In order for this child to participate in the school athletic program, we request you complete this form for our physician's evaluation. Thank you.

Examiner's diagnosis and recommendation:

Date: _____

Diagnosis: _____

Visual A) Without Correction Right _____

Acuity Left _____

B) With Correction Right _____

Left _____

1. Is any pathology of the retina present? _____

2. Please state whether or not severe Myopia is present, even if correctable _____

3. State sports student may participate in:

Contact _____

Endurance _____

Other _____

4. To participate student is to use glasses

Safety _____

Regular _____

Contact Lens _____

5. Student may participate without wearing glasses _____

AFFIX PHYSICIAN'S STAMP

**

_____ (Examiner's Signature)

Address _____