MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

MISSOURI EYE EXAMINATION FORM FOR SCHOOL

IDENTIFYING INFORMATION	PATIENT/PROVIDER IDENTIFIER
STUDENT NAME	PROVIDER LAST NAME (First Four Digits)
DATE OF BIRTH OF STUDENT	SSN (Last four digits of student)
PARENT / GUARDIAN NAME	

CASE HISTORY

DATE OF EXAM

OCULAR HISTORY:	Normal ☐ or Positive for:
MEDICAL HISTORY:	Normal ☐ or Positive for:
DRUG ALLERGIES:	NKDA ☐ or Allergic to:
FAMILY OCULAR and MEDICAL HISTORY:	☐ Amblyopia ☐ Strabismus ☐ Glaucoma ☐ Diabetes Other:

OTHER PERTINENT INFORMATION

EXAM

	NORMAL	ABNORMAL	Not Able to Assess
AMBLYOPIA	☐	☐	☐
STRABISMUS	☐	☐	☐
INTERNAL EYE HEALTH	☐	☐	☐
EXTERNAL EYE HEALTH	☐	☐	☐
VISUAL ACUITY	☐	☐	☐
BINOCULAR VISION	☐	☐	☐

	OD			OS		
Distance Unaided Acuity (20 ft)	20 /			20 /		
Distance Best Corrected Acuity (20 ft)	20 /			20 /		
Near Unaided Acuity (14 in)	20 /		(eq)	20 /		(eq)
Near Best Corrected Acuity (14 in)	20 /		(eq)	20 /		(eq)

REFRACTION

OD					
OS					

DIAGNOSIS

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

OTHER:

TREATMENT RECOMMENDATIONS

1	Glasses Prescribed ☐ Yes ☐ No
2	
3	

Spectacles to be worn for:

☐ Constant Wear ☐ Distance Vision Only ☐ Near Vision Only ☐ May be removed for recess/PE

PAYER

☐ Insurance ☐ MO HealthNet ☐ Complimentary ☐ Other form of payment **TOTAL COST:**

EXAMINER NAME	☐ **OD** ☐ **MD/DO**	DATE