

## **VISION ACTION PLAN**

## \*TO BE FILLED OUT BY THE EYE DOCTOR AND RETURNED TO THE SCHOOL NURSE OR HEALTH MANAGER\*

Please update the Vision Action Plan annually or when the treatment plan changes. This Plan is designed for use at home and school, and also as a supplement to eye exam results provided to the primary care provider. Its goal is to facilitate support of the treatment plan.  Student Name:	
Student Name:	This form was completed (MM/DD/YYYY): A follow-up eye exam is needed (MM/YYYY):
School (Name/Address/Fax):	
School (Name/Address/Fax):	
Primary Care Provider (Name/Address/Fax):	
Date of eye exam (MM/DD/YYY): Eye doctor (Name/Practice/Phone/Fax): Office or store where eyeglasses were obtained (if known):  CURRENT DIAGNOSIS:  BEST VISUAL ACUITY (circle one: with eyeglasses without eyeglasses ) Right Eye Both Eyes  Edit Eye Both Eyes  CURRENT TREATMENT PLAN:  Eyeglasses are not needed at this time  Eyeglasses should be worn:  All of the time when awake  Only when the child needs to see clearly at distance Only when the child needs to see clearly up close  An eye patch should be worn:  To cover right eye	
Eye doctor (Name/Practice/Phone/Fax): Office or store where eyeglasses were obtained (if known):  CURRENT DIAGNOSIS:  BEST VISUAL ACUITY (circle one: with eyeglasses without eyeglasses ) Right Eye Left Eye Both Eyes  CURRENT TREATMENT PLAN:	Timely eare Frontier (Hamey-Kadressy Tak).
Office or store where eyeglasses were obtained (if known):  CURRENT DIAGNOSIS:  BEST VISUAL ACUITY (circle one: with eyeglasses   Both Eyes	Date of eye exam (MM/DD/YYYY):
BEST VISUAL ACUITY (circle one: with eyeglasses without eyeglasses)  Right Eye	Eye doctor (Name/Practice/Phone/Fax):
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Right Eye Left Eye Both Eyes  CURRENT TREATMENT PLAN:    Eyeglasses are not needed at this time     Eyeglasses should be worn:   All of the time when awake   Only when the child needs to see clearly at distance   Only when the child needs to see clearly up close     An eye patch should be worn:   To cover right eye   To cover left eye   Total of   hours per day ( hours at home, hours at school)     *If the child has been prescribed eyeglasses, eyeglasses should be worn when they wear the patch.     Eye drops will be used instead of a patch and will be given by These eye drops will cause the pupil to get larger and the vision to blur in the better-seeing eye.     Other:	CURRENT DIAGNOSIS:
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ADDITIONAL NOTES AND RECOMMENDATIONS:	
	□ Other:
	ADDITIONAL NOTES AND RECOMMENDATIONS:
	TO DE COMPLETED BY DADENT (CHARDIAN)
TO BE COMPLETED BY PARENT/GUARDIAN  I give permission for this completed form to be sent to the school nurse or health manager at my child's school and for s/he to share the information with my child's teacher and other school professionals who are directly involved with my child. Also, I give permission for this completed form to be send to my child's primary care provider.	I give permission for this completed form to be sent to the school nurse or health manager at my child's school and for s/he to share the information with my child's teacher and other school professionals who are directly involved with my child. Also, I give permission for this completed form to be send to my child's primary care
	Parent/Guardian Signature: Date:
	Parent/Guardian Signature: Date: