Nombre del(a) Estudiante: _____

Número de estudiante: _____

Visual Medical Certification

I. Report of Examination

Distance:

***Without glasses**	***With Best Correction**	***Percentage Loss with Rx:**
OD:_____	OD_____	OD_____
OS: _____	OS _____	OS _____

Observations: _____

Reading:

***Without glasses**	***With Best Correction**	***Percentage Loss with Rx:**
OD:_____	OD_____	OD_____
OS: _____	OS _____	OS _____

Observations: _____

Visual Field: _____ Normal _____ Restricted _____

Binocular Function:

A) Does the patient have useful binocular vision in all directions with correction?

For distance:_____Yes _____No
For Near: _____Yes_____No

B) Is depth perception present?_____Yes_____No
C) Color perception:_____Normal_____Not normal
D) If color blind, which colors? _____

II. Diagnosis

Eye pathology: _____

Primary condition: _____

Secondary condition: _____

Causes of condition: _____

Characteristics of condition:_____Stable_____Progressive_____Improving

_____Recurrent_____Permanent_____Other: specify _____

Prognosis:_____

Specify functional limitations:

_____

_____

III. Recommendations

Treatment recommended:

_____

_____

If the treatment if surgical, please specify the expected outcome of procedure:

_____

_____

Specify academic reasonable accommodations:

_____

_____

_____

Other recommendations:

_____

_____

_____ _____

Nombre del(a) especialista Firma del(la) especialista

_____ _____

Especialidad Número de licencia

_____ _____

NPI Fecha

_____

Dirección y teléfonos de oficina