



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STRABISMUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTERNAL EYE HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EXTERNAL EYE HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VISUAL ACUITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BINOCULAR VISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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 <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> OD <input type="checkbox"/> MD/DO	DATE
---------------	--	------