SCOTT KEY CENTER
HELPING SHAPE FUTURES

Vision Evaluation Report

Name: _____

Date: _____

Diagnosis:

Visual Acuity – Right 20/_____ Left 20/_____

With glasses -- Right 20/_____ Left 20/_____

Muscle Balance -_____ Fusion - _____

Stereopsis - _____ Color Vision - _____

Recommendations:

Use of Glasses: Constantly _____ Part Time _____ None _____

Suggestions for vocational center regarding symptoms to watch for:

Date for next examination: _____

Signature of Eye Specialist: _____