VISION ACTION PLAN

☐ **This Vision Action Plan is valid from _____ to _____.** **–OR-**

☐ **Initial treatment plan only. A follow-up eye exam is needed in _____ (month/year) to complete this Vision Action Plan.**

Student Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Preferred Phone: _____ Alternate Phone: _____

School: _____ Health manager/school nurse: _____

Date of eye exam: _____

Eye doctor (Name/Practice): _____

Office or store where eye glasses were obtained: _____

CURRENT DIAGNOSIS: _____

CURRENT TREATMENT PLAN:

☐ Eye glasses should be worn:

- ☐ All of the time when awake
- ☐ Only when the child needs to see small things that are far away
- ☐ Only when the child needs to see small things that are within arm's length

☐ 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 eye glasses, the child should wear their eye glasses when they wear the patch.

☐ Eye drops will be used instead of a patch and will be given by the parent at home. These eye drops will cause the pupil to get larger and the vision to blur in the better-seeing eye.

ADDITIONAL NOTES AND/OR RECOMMENDATIONS:

_____

_____

Parent/Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Health Manager/School Nurse Signature: _____ Date: _____