First Name	Last Name	HAS ID _____

Date	O Male O Female	DoB	Age (years) O Not sure
Event	Location	O Athlete O Unified partner	Sport
Delegation		SO Program	
Cell phone # (optional)		**Number is O Athlete's O Parent's / Guardian 's**	

History

When was your last eye exam?
- O Less than 1 year
- O 1-3 years
- O More than 3 years
- O Never
- O Unknown

Do you experience any of the following
- ☐ Difficulty seeing: ☐ Far ☐ Near
- ☐ Headaches
- ☐ Sensitivity to light
- ☐ Double vision: ☐ Far ☐ Near

Special Olympics
Lions Clubs International
Opening Eyes®

Do you wear corrective lenses (glasses or contacts)? O No O Yes

☐ *Standard Rx* ☐ *Sports Rx* ☐ *Contact lenses*

☐ Full time ☐ Near only ☐ Far only O Soft O Hard

Please check what is worn during screening: O Without Glasses O With Glasses O With contact lenses

Current prescription

	Sphere	Cylinder	Axis	Add
Right Eye				
Left Eye				

Visual Acuity FAR **Right Eye** 20 /___ ☐ *Unable to test* **Left Eye** 20 /___ ☐ *Unable to test*

O Lea	O Walk up	O Light projection/Light perception	O Walk up	O Light projection/Light perception
		O No light perception		O No light perception
	Other:		Other:	

NEAR **Both Eyes** 20 /___ ☐ *Unable to test*

O Lea	O Light projection/Light perception	O No light perception	Other:

Cover Test FAR ☐ *Unable to test*

☐ orthophoria O PHORIA range 02-99 ___ O eso O exo O hyper

O TROPE range 02-99 ___ O eso O exo O hyper O hyper/eso O hyper/exo

O Latent Nystagmus *O Constant O Intermittent*

NEAR ☐ *Unable to test*

☐ orthophoria O PHORIA range 02-99 ___ O eso O exo O hyper

O TROPE range 02-99 ___ O eso O exo O hyper O hyper/eso O hyper/exo

O Constant O Intermittent

Color Vision ☐ *Unable to test* CVME: Trial 1_ /9 If less than 8/9 Trial 2_ /9 **Stereopsis** ☐*Unable to test* __ / 6 ☐RDE ☐PASS

Color√: __/14 symbols (does not include demonstration card)

Autorefraction

		Sphere	Cylinder	Axis
☐ *Unable to test*	Right Eye			
☐ *Unable to test*	Left Eye			

Eye Health External **Right Eye** ☐ *Unable to test* **Left Eye** ☐ *Unable to test*

O Nystagmus

Right Eye			Left Eye		
☐Normal	☐Lid anomaly	☐Pterigium/pinguecula	☐Normal	☐Lid anomaly	☐Pterigium/pinguecula
	☐Blepharitis	☐ Corneal anomaly		☐Blepharitis	☐ Corneal anomaly
	☐Conjunctivitis	☐ Iris anomaly		☐Conjunctivitis	☐ Iris anomaly
	☐Ptosis			☐Ptosis	

Abnormality:

Internal **Right Eye** ☐ *Unable to test* **Left Eye** ☐ *Unable to test*

Right Eye			Left Eye		
☐Normal	☐ Cataracts	☐ Retinal anomaly	☐Normal	☐ Cataracts	☐ Retinal anomaly
	☐ Coloboma	☐ Optic Nerve anomaly		☐ Coloboma	☐ Optic Nerve anomaly
		☐ Glaucoma suspect			☐ Glaucoma suspect

Abnormality:

IOP **Right Eye** _____ **Left Eye** _____ **Pupils** O Normal O Abnormal: _____

☐ *Unable to test* O Icare O Noncontact ☐ *Unable to test*

	Right Eye	Left Eye	OU	Add
Retinoscopy	20/ ___	20/ ___	20/ ___	
Refraction	20/ ___	20/ ___	20/ ___	20/ ___

Recommendations:

O **No new Rx** O No glasses recommended O No change in glasses recommended ☐ **Sunglasses (plano)**

O **New Rx** ☐ **Full time Rx** ☐ **Distance only** ☐ **Close work only**

PD __/__	Sphere	Cylinder	Axis	VA Distance	Distance OU	VA Near (OU)	ADD
Right eye				20 / ___	20 / ___	20 / ___	
Left eye				20 / ___			

☐ **Sports goggles:** O Plano O Rx

Right eye				20 / ___
Left eye				20 / ___

Referral to: ☐ Optometrist ☐ Ophthalmologist ☐ Primary care physician ☐ Neurologist ☐ Other: _____

Urgent Referral 0 Yes 0 No **Additional comments:**