VISION SCREENING TEST

Student Name: ____

Date of Birth: ______________

Date of Exam: ______________

Vision

Right: 20/___ Left: 20/____ Pass____ / Fail ______

With correction _______ Without correction _________

Suresight ______ Snellen ___________ Titmus __________

(MUST BE SIGNED BY AN PHYSCIAN AND SUBMITTED ON THE FIRST DAY OF CLASS)
I, ____________________________ ______________   (STUDENT NAME) (DATE)   By ____________________________ and received a visual acuity score of at least 20/40   (PHYSICIAN OR INSTRUCTOR