National Beep Baseball Association

Vision Examination Report

(To be completed during an ophthalmological or optometric exam)

Name of Player: ________________________________

Date of Birth: _____________________ Team Name: ______________________

Street: ____

City: _________________________________ State:______ Zip:___________

Country: ____

Parent/Guardian (if under 18): ____

Phone: ____

Email: ____

Attention Eye-Care Professional

Visual Acuity If the acuity can be measured, complete the section below using Snellen acuities or Snellen equivalents, or NLP, LP, HM, or the distance at which the patient sees the 20/200 letter.

Best Corrected *OD:*	***Best Corrected*** *OS:*	***Best Corrected*** *OU:*

Diagnosis (primary cause of vision loss):

____

Can this person's vision be improved (choose one)? Yes__ No___

If the individual has acuities that are better than 20/70 in their best eye, then they must have a field test performed (Confrontation is not acceptable. If a field test is performed then please attach a copy of the test. ***Please note that a field test only needs to be done if the individual has a corrected acuity greater than 20/70.***

Describe the restriction(s):

OD: ___________________ OS: ________________ OU: ___________________

National Beep Baseball Association

Vision Examination Report

By signing below the vision professional certifies that all the information provided is true and current.

Name of vision professional conducting the exam (print name):

____

Name of Clinic: ____

Phone: __________________ Email: _______________________________

Date of Exam: ______________

Signature of vision professional: ____________________________

Date: __________________________