National Beep Baseball Association

Vision Examination Report

(To be completed during an ophthalmological or optometric exam)

Name of Player: _____ Date of Birth: _____

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.

Non-corrected OD:	Non-corrected OS:	Non-corrected OU:	**Corrected** OD:	**Corrected** OS:	**Corrected** OU:

If the acuity cannot be measured, mark below the most appropriate estimation with an "**X**".
__Legally blind (20/200 or worse) __Between 20/70 and 20/199 __Better than 20/70
__Visually impaired due to visual field of 30 degrees or less in both eyes

Visual Field Test

Type of field test (Confrontation is not acceptable. Attach a copy of the test.):
__No apparent visual field restriction exists. __A visual field restriction exists

Describe the restriction:

OD: _____ OS: _____ OU: _____

Diagnosis (primary cause of vision loss): _____

Can this person's vision be improved (choose one)? __Yes __No

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: _____

Player Authorization

I the below undersigned authorize that the National Beep Baseball Association can receive either verbal or written confidential information. The representative from the National Beep Baseball Association must be a member of the Vision Committee. This representative must only be inquiring into the agreed information for the purpose of certifying that my vision meets the criteria of their vision policy. The National Beep Baseball Association agrees that they will not share specifics about this information with third parties. The information I authorize the National Beep Baseball Association to receive is information about my visual acuity, visual field, and the primary diagnosis which causes my visual impairment. The National Beep Baseball Association is authorized to receive this information from the above signed vision professional. I authorize that my confidential information may be released to the National Beep Baseball Association no later than one (1) year from the date listed next to my signature.

Name of Player (Print): _____

Signature of Player: _____
Date: _____

Name of parent/ guardian if under 18 (Print): _____

Signature of parent/ guardian (if under 18): _____
Date: _____

Scan and email this form in its entirety to vision@nbba.org