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: _____

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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: _____