

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.

Best Corrected <i>OD:</i>	Best Corrected <i>OS:</i>	Best Corrected <i>OU:</i>

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: _____

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: _____