EYE EXAMNATION
Dr. Mack S. Brown – Optometrist
716 S. Dora
707-462-5361

STUDENT COMPLETES THIS SECTION

NAME		SOCIAL SECURITY NUMBER	
ADDRESS	CITY	STATE	ZIP
BIRTH DATE	HOME TELEPHONE NO.	WORK TELEPHONE NO.	

OPTOMETRISTS COMPLETES THIS SECTION

Check each item in appropriate box to show "Qualified" or "Not Qualified." See instructions for condition or defects that must be noted. Explain any special findings or test results **NOT** in an acceptable tolerance range. Use additional sheets, if needed.

ID Confirmed ☐ YES ☐ No Name Date of Exam

ALL BOXES MUST BE COMPLETED	QUALIFIED	NOT QUALIFIED	EXPLANATION IF NECESSARY
Visual Acuity: Must be at least 20/40 in each eye with/without corrective lenses **UNCORRECTED** / **CORRECTED** / **CONTACTS?** Both 20/____ 20/____ ☐ YES ☐ NO Left 20/____ 20/____ Are the lenses well Right 20/____ 20/____ adapted and tolerated? ☐ YES ☐ NO			
Peripheral Vision: Left: Right: Express in degrees. (Must be at least 70°)			
Pupillary Reflex. Light Check both Eyes.			
Eyes. Note any evidence of disease or injury.			

STUDENT'S IDENTITY VERIFIED BY:
☐ Photo ID (Specify ID used):

SIGNATURE OF AUTHORIZED MEDICAL EXAMINER **X**	DATE OF EXAM	LICENSE OR CERTIFICATE NO./ISSUING STATE
NAME (*PRINT*)		PLACE DOCTORS'S OFFICE STAMP IN THIS SPACE
TITLE ☐ Physician (☐ M.D. ☐ D.O.) ☐ Optometrists	TELEPHONE NO.	
ADDRESS CITY STATE ZIP		

This section to be filled out and signed by a HEP/CAMP representative.

Students Name	Date of referral	Purchase Order #
(Purpose of referral) ☐ Vision Exam		
HEP/CAMP Staff Person	Date	Signature

Mendocino Community College
High School Equivalency Program
1000 Hensley Creek Rd
Ukiah, CA 95482
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Fax: 707-467-1009