MARICOPA COMMUNITY COLLEGE DISTRICT ALLIED HEALTH PROGRAMS

HEALTH AND SAFETY DOCUMENTATION FORM

PHOENIX COLLEGE DENTAL PROGRAMS

OPHTHALMIC (VISION) EXAM RECORD

Student Name _____

OPHTHALMIC RECORD

I have examined _____ and find his/her vision to be:
Student Name

___Satisfactory ____Unsatisfactory

I recommend the following:

_____ _____
Ophthalmologist, Optometrist or Physician's signature Date signed