



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