DEPARTMENT OF THE ARMY
ARMED FORCES EYE AND VISION READINESS SUMMARY

For use of this form, see DA Pam 40-506; the proponent agency is OTSG.

Privacy Act Statement

AUTHORITY: DoD Directive 6200.04, DoD Instruction 6055.1, E.O. 12196, AR 40-66, AR 40-501, and AR 600-8-101

PRINCIPLE PURPOSE (S): Department of Defense Force Health Protection policy requires the Services to conduct annual health assessments of military personnel, including individual medical readiness (IMR) assessments. Visual performance and possession of required optical devices factor into IMR calculations to provide medical readiness data to unit commanders. Following an evaluation by an eye care provider, Soldiers may use this form to capture spectacle prescription and visual performance data (visual acuity) for entry in the Medical Readiness Protection System (MEDPROS).

ROUTINE USE (S): None; The DOD blanket routine uses may apply to this collection.

DISCLOSURE: Voluntary; however, failure to provide the information may result in delays in assessing refractive and vision health needs for military service. Information on this form may also be used to determine Vision Readiness Classification.

1. SERVICE MEMBER'S NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH	3. BRANCH OF SERVICE

4. UNIT OF ASSIGNMENT	5. UNIT ADDRESS

EXAMINATION RESULTS:

To the Doctor: The patient who presented this form to you is a member of the United States Armed Forces. Please complete the information below to assist the Department of Defense (DOD) and your patient to meet medical readiness tracking requirements. The DOD will use the examination results on this form to determine your patient's fitness for prolonged duty without ready access to eye care. The DOD will not use the information on this form to address or document your patient's comprehensive ocular health or visual needs.

6. DATE OF VISION SCREENING *(YYYYMMDD):* DATE OF SPECTACLE RX *(YYYYMMDD):*

(1) UNCORRECTED DISTANCE VISUAL ACUITY	(2) BEST CORRECTED DISTANCE VISUAL ACUITY
Right Eye 20/	Right Eye 20/
Left Eye 20/	Left Eye 20/
Both Eyes 20/	Both Eyes 20/

(3) IF ≥ 45, UNCORRECTED NEAR VISUAL ACUITY	(4) IF ≥ 45, BEST CORRECTED NEAR VISUAL ACUITY
Both Eyes 20/	Both Eyes 20/

(5) SPECTACLE PRESCRIPTION (MINUS CYLINDER FORMAT, IF NEAR VISION ONLY ANNOTATE IN BIFOCAL FORM): ____________

	SPHERE	CYLINDER -	AXIS	ADDITION +	PRISM
Right Eye					
Left Eye					

(6) PUPILLARY DISTANCE: FAR ______________ mm NEAR ______________ mm

(7) Does the patient have any ocular condition(s) that may present problems in austere environments far removed from routine medical care?

YES ☐ If yes, please state condition(s):
NO ☐

(8) Will the patient require a 180-day supply of medication(s) to treat an ophthalmologic condition(s)?

YES ☐ If yes, please provide medication(s) and dosage(s):
NO ☐

(9) Has the patient undergone a refractive surgical procedure(s) in the past?

YES ☐ If yes, please provide month, year and type of procedure(s):
NO ☐

7. DOCTOR'S PRINTED NAME	8. STATE LICENSE NUMBER	9. DOCTOR'S ADDRESS & TELEPHONE OR E-MAIL ADDRESS
10. DOCTOR'S SIGNATURE		