South Carolina Department of Labor, Licensing and Regulation
South Carolina State Athletic Commission
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11329 • Columbia • SC 29211-1329
Phone: 803-896-4571 • Contact.Athl@llr.sc.gov • Fax: 803-896-4350
llr.sc.gov/ath

OPHTHALMIC HISTORY FORM

(WRESTLERS ARE EXEMPT FROM THIS FORM)

APPLICANT: Fill this form out then take to the optometrist's office to have completed. This form must be sent in by the optometrist's office; otherwise it will not be accepted.

Name: _____

Date of Birth: _____ Age: _____ Social Security (Last 4 digits only): xx-xxx-_____

Boxing History:

How many fights have you had	Dates From - To	Total	Won	Lost	(T) K.O.'d
Amateur					
Professional					
Date of last KO					

Any eye injuries: YES / NO Any eye meds:YES / NO If yes list type(s): _____

_____

Have you has any eye diseases or surgery? YES / NO If yes, explain: _____

_____

Have you ever had any retina surgery or laser treatment of the eye? YES / NO If yes, explain: _____

_____

Have you ever had refractive or laser correction to your vision? YES / NO If yes, explain: _____

_____

Name(s) and Address of any physicians who have treated your eyes: _____

_____

_____

ATTESTATION:

I certify (or declare) under penalty of perjury, that the foregoing history is true and correct. Should I furnish any false or incomplete information, I hereby agree that such act shall constitute the cause for denial, revocation or disciplinary action to my license in the State of South Carolina.

_____ _____

Applicant's Signature Date

EYE EXAMINATION

Optometry Office should mail or fax both forms to our office. Please see page 1 for address or fax number.

Patient's Name: _____ Date of Birth: _____ Social Security: xx-xxx-_____
(Last 4 digits only)

Ophthalmic Exam

	Right Eye	Left Eye
Vision with naked eye		
Vision with corrective lenses		
Abnormalities in:		
Conjunctiva or Eyelids		
Eye Muscles or Strabismus		
Cornea; lenses		
Anterior Chamber, Chamber Angle (include Gonioscopy)		
Vitreous		
Peripheral Retina		
Macula		
Optic Nerve		
Visual Field (Goldman III 4e or equivalent)		
Eye Pressure, mm.Hg. (list test)		

Optometrist's remarks on abnormal findings: _____

_____

_____

_____

Conditions which would disqualify the applicant/licensee from this license: _____

_____

After completing the above eye examination and test results (Circle One):

I certify that as a result of this examination, **I DO / I DO NOT** feel the applicant/licensee is eligible to be licensed.

_____ _____ _____
Signature of Ophthalmologist or Optometrist | Doctor's License Number | Date

_____ _____
Print or Stamp Name of Ophthalmologist or Optometrist | Phone Number (XXX) XXX-XXXX

_____ _____
Office Street Address, City, State, Zip | Fax Number (XXX) XXX-XXXX