



South Carolina Department of Labor, Licensing and Regulation

South Carolina Athletic Commission

P.O. Box 11329 • Columbia, SC 29211
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Contact.Athl@llr.sc.gov
www.llr.state.sc.us/POL/Athletic/



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