INTERNATIONAL BLIND GOLF ASSOCIATION

SIGHT CLASSIFICATION FORM

Section 1 should be completed by the person being tested.

Section 2 is for Office use only.

Section 3 (overleaf) should be completed by an Ophthalmologist or Optometrist.

SECTION 1

NAME _____

ADDRESS _____

_____

_____ **CODE** _____

TEL _____ **E-MAIL** _____

DO YOU WEAR SPECTACLES OR CONTACT LENSES WHEN YOU PLAY GOLF?
YES / NO

PLEASE NOTE THE USE OF VISUAL DISTANCE AIDS SUCH AS MONOCULARS IS NOT PERMITTED IN COMPETITION OR OFFICIAL PRACTICE.

THE RESULTS OF THIS TEST WILL BE HELD ON A DATA BASE AND THE CATEGORY WILL BE DISPLAYED ON THE I.B.G.A. WEBSITE.

SIGNED_____**date**_____

SECTION 2

FOR OFFICE USE ONLY

CATEGORY B1 B2 B3 OVER B3

NAME OF ASSESSOR (PLEASE PRINT) _____

SIGNATURE OF ASSESSOR _____

POSITION HELD AND DATE _____

SECTION 3

TO BE COMPLETED BY THE OPHTHALMOLOGIST OR OPTOMETRIST.

Name of person being tested_____

PLEASE TEST THE VISUAL ACUITY OF THIS PERSON USING BEST SPECTACLE / CONTACT LENS CORRECTION.

TEST BINOCULAR AND BETTER EYE ACUITY BUT RECORD ONLY THE BETTER RESULT ATTAINED.

PLEASE RECORD THE RESULT ON THE HORIZONTAL SCALE BELOW
IF THE RESULT IS LESS THAN COUNT FINGERS PLEASE CHECK WHETHER HE/SHE CAN DIFFERENTIATE BETWEEN A BLANK SHEET OF WHITE PAPER AND THE SHEET OF PAPER WITH THE BLACK SYMBOL BELOW ON IT AT ANY DISTANCE OR IN ANY DIRECTION – I.E. D.S.

20/160 20/200 20/320 20/400 20/630 20/800 20/1000 cf DS PL NPL

DID THE TESTEE WEAR SPECTACLES / CONTACT LENSES WHEN TESTED

YES / NO

NAME OF OPTHALMOLOGIST OR OPTOMETRIST

PLEASE PRINT _____

SIGNATURE_____-_____

QUALIFICATION_____DATE_____