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 DATABASE 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_____________________