

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 OPHTHALMOLOGIST OR OPTOMETRIST

PLEASE PRINT _____

SIGNATURE _____ - _____

QUALIFICATION _____ **DATE** _____



