FERNDALE SCHOOL DISTRICT NO. 502
Ferndale, WA 98248

VISION SCREEN REFERRAL

Student: _____
Grade: _____
School: _____
Address: P.O. Box _____
City, State, Zip: _____
Phone: (360)_____Fax: (360) _____

Address: _____
City, State, Zip:_____
Phone: _____

Dear Parent/Guardian:

Results of eye screening at school indicate that there is a need for your child to have a professional eye examination**. Please take this form with you** when the eye examination is to be done, and return this completed report to the attention of the "School Nurse" at the school office. If you need help finding a provider or have any other questions, do not hesitate to call me.

Thank you,

_____ _____ _____
School Nurse *Date* *Phone*

Screening results: Right Eye _____/_____; Left Eye _____/_____; ____with glasses on.
Other findings:_____
_____ Student reports glasses: Lost, broken, or not available at school for school screening. Annual exam recommended.
*Funding resources for exam/glasses is available upon request to the school nurse.

RECOMMENDATION FROM PROFESSIONAL EYE EXAMINATION:

1. Glasses
   - ❑ None needed
   - ❑ Prescribed – to be worn_____
   - ❑ Other_____
2. Best corrected acuity with glasses: Right_____ Left_____
3. Recommendations:
   - ❑ Preferential seating, comments_____
   - ❑ Special visual aids, type_____
   - ❑ Return for re-evaluation, (when)_____
   - ❑ Consider as visually handicapped_____

_____ _____
Eye Care Specialist's Signature *Date of Exam*

_____ _____
Printed name *Phone*

Parents/Guardians, please return this report to school