



Vision Referral

Date: \_\_\_\_\_

Dear Parent/Guardian:

A recent vision screening test given in school has indicated that your child may have a vision problem which requires attention. We recommend that your child have an examination with an eye specialist.

Please request that the eye specialist complete the form below and return it to your child's School Nurse. If your child is under the care of an eye specialist, please have this form completed for your child's school health records. Thank you.

School Nurse: \_\_\_\_\_

Forgot glasses: \_\_\_\_\_

Broken glasses: \_\_\_\_\_

Eye Examination Report

Student Name: \_\_\_\_\_ Date Examined: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom#: \_\_\_\_\_

Visual Acuity without Lenses: Right: \_\_\_\_\_ Left: \_\_\_\_\_ Both: \_\_\_\_\_

Visual Acuity with Lenses: Right: \_\_\_\_\_ Left: \_\_\_\_\_ Both: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Glasses Prescribed (Yes or No): \_\_\_\_\_ For Constant Wear (Yes or No): \_\_\_\_\_

Special Seating in Classroom Advisable (Yes or No): \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name Eye Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Eye Specialist Signature: \_\_\_\_\_ Date: \_\_\_\_\_