



Dr. A. Katrise Perera, Superintendent

## Gresham-Barlow School District No. 10Jt

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# VISION SCREENING CERTIFICATION

**Note:** This form applies to all students 7 years of age or younger and who are beginning an educational program with the educational provider for the first time.

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **VISION SCREENING**

See 2013 Oregon HB3000 Section 1: (2)(a) through (3)(b)

#### **SECTION ONE:**

Did your student receive a vision screening or eye exam by a provider other than at school?  YES  NO

Vision screening or eye exam date: \_\_\_\_\_ Results:  Pass  Referred (Did Not Pass)

Name of provider who conducted the screening or eye exam: \_\_\_\_\_

- OR -

#### **SECTION TWO:**

I have previously submitted certification to: \_\_\_\_\_

(Name of School/Educational Provider)

- OR -

#### **SECTION THREE:**

I am not providing certification of vision screening/exam due to:

Submitted to Prior School/Educational Provider  Religious Beliefs  Financial Burden

Do Not Have Access to Provider  Unable to Schedule Appointment with Provider

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date