



Dr. A. Katrise Perera, Superintendent

Gresham-Barlow School District No. 10Jt

1331 NW Eastman Parkway, Gresham, OR 97030-3825

www.gresham.k12.or.us

Phone: (503) 261-4550

Fax: (503) 261-4553

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