



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