

CHAPPAQUA CENTRAL SCHOOL DISTRICT

VISION SCREENING PARENT/GUARDIAN NOTIFICATION OF RESULTS AND REFERRAL

Student Name: _____ DOB: ____/____/____ Date: _____
 Student Address: _____ Grade: _____
 School Name: _____ School Phone: _____

Dear Parent/Guardian:

- ☐ Your child was screened for vision at school and no issues were noted.
☐ Your child was screened for vision at school, he/she had some trouble reading the charts. Screening results do not always mean there is a problem. Please have your child's eyes examined by an eye care professional and ask them to complete this form. Return the completed form to the school as soon as possible.
☐ Staff observations attached.

School Vision Screening Results:

Vision Test	With Lenses	Without Lenses
Distance Vision Acuity	Right Eye 20/_____ Left Eye 20/_____	Right Eye 20/_____ Left Eye 20/_____
Near Vision Acuity	Right Eye 20/_____ Left Eye 20/_____	Right Eye 20/_____ Left Eye 20/_____
Color Perception	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	
Optional: Hyperopia Screening	<input type="checkbox"/> Able to see 20/_____ with diopter lens strength + _____	

School Health Professional: _____ Date: _____

Report of Professional Eye Examination to the School

Date of examination: _____ Corrected Visual Acuity Right 20/_____ Left 20/_____

Vision Test	With Lenses	Without Lenses
Distance Vision Acuity	Right Eye 20/_____ Left Eye 20/_____	Right Eye 20/_____ Left Eye 20/_____
Near Vision Acuity	Right Eye 20/_____ Left Eye 20/_____	Right Eye 20/_____ Left Eye 20/_____
Color Perception	Results if Fail:	
Optional: Hyperopia Screening	Able to see 20/_____ with diopter lens strength + _____	

Peripheral vision, if fields are restrictive, indicate degree and location: _____
 Diagnosis: _____
 Plan: ☐ No Treatment at this time ☐ Eyeglasses ☐ Contact Lenses ☐ Patch ☐ Other: _____
 Frequency of use: ☐ Wear at all times ☐ For distance only ☐ For reading tasks only ☐ Other: _____
 Physical Education: ☐ Wear for Physical Education ☐ Remove for Physical Education
 Medical Provider: _____ (Signature) _____ (Phone) _____ (Date)

For school use:

- ☐ Completed form received on date: _____
☐ Completed form not returned to school