VISION REFERRAL LETTER

Student Name	Birthdate	School	Grade

School Nurse	Phone Number	Date

Dear Parent:
State law requires that students who are unable to pass vision screening be referred for a professional eye exam. **A student with uncorrected visual acuity is at a disadvantage for learning.** Here are the results of the recent vision screening.

	Without Glasses		With Glasses/Contacts	
	RE	LE	RE	LE
Distance Vision				
Near Vision				
Comments				

Ophthalmologist/Optometrist Exam:

	Without Correction		With Correction	
	RE	LE	RE	LE
Distance				
Near				

Glasses Prescribed: ☐ Yes ☐No

Glasses should be worn: ☐ Distance ☐Work Near Work ☐At all times

Other recommendations: _____

Student should return _____

Doctor's stamp:	Please fax completed form to:

Doctor's Signature Date

Parent's Signature (Permission to send form) Date