East Ramapo Central School District
Office of Special Student Services
105 South Madison Avenue
Spring Valley, New York 10977

PARENT NOTIFICATION REGARDING VISION

DATE:______________________

NAME:____

SCHOOL/GRADE/HOMEROOM:____________________________

Dear Parent/Guardian:
Today, your child did not perform in a satisfactory manner in our mandated vision screening examinations. A complete professional eye examination is necessary to determine the need for treatment**. This form must be completed and the entire page returned to the school nurse**. **Students with limited or no vision in one (1) eye must return the completed form prior to participating in physical education.**

To the Examiner:
The following signs of eye difficulty have been noted by the school nurse___________________________

____

The above student may not participate in contact/collision sports if he/she is more than minus six (6) diopters of myopia. Students with an uncorrected Snellen score of more than 20/70 (for example:20/80 or 20/100) in either eye must complete and return this form before they may compete in sports. Your diagnosis and recommendation will helping planning for this child's school program.

___________________________________ ____________________________
School Nurse Phone Number

REPORT OF EYE SPECIALIST

1. DIAGNOSIS: **R:**_________________________ **L**_______________________________
2. VISUAL ACUITY (*If myopic include diopters of myopia)*

   without correction **R**________________ with correction**R**____________ Diopters **R**________

   L________________ **L**____________ **L**________

3. Corrected near visual acuity **R**______________ **L**______________
   If fields are restricted, indicate degree and location____

   ____

4. Recommendations (include type of prescription)____

   ____

5. Under what conditions should glasses be worn?____

   ____

6. Should physical activities be limited because of eye condition? Yes_______________ No_______________
   If yes, please specify____
7. Protective eye googles are to be worn for physical education Yes________________ No_______________
8. Date for re-examination_______________________________

____ ____________________________
Examiner's Signature and Title Date of Examination

____ ____________________________
Examiner's Address/ Phone Number Examiner's Stamp

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