Seneca Valley School District

Tracy L. Vitale, Ed.D.
Superintendent of Schools

Administration Center
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PHONE: (724) 452-6040
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VISION SCREENING REFERRAL

Name:_____ Grade:_____

Dear Parent/Guardian:

We have completed the vision screening service provided as part of the School Health Program. Results of your child's vision test indicate the need for an eye examination by an eye care specialist. The findings of the school vision screening test are recorded below:

FINDINGS: SCHOOL VISION SCREENING TESTS Date:_____

1. Visual Acuity:

	FAR Right / Left	**NEAR** Right / Left
With correction:	____ ____ Passed ___ Failed ____	____ ____ Passed ___ Failed ___
Without correction:	____ ____ Passed ___ Failed ____	____ ____ Passed ___ Failed ___

2. Convex Lens (excessive farsightedness): Passed ____ Failed ____ Not Tested ____

3. Color Vision: *Eye exam **not** required. Passed ____ Failed ____ Not Tested ____

4. Stereo/Depth Perception: Passed ____ Failed ____ Not Tested ____

Note: Tests 2, 3 & 4 need to be done only once, usually during the early elementary years.

Comments:_____
_____

Since uncorrected vision disorders can affect learning potential, it is important to have your child's eye care specialist complete the form on the back of this letter and return it to school. ***Please note:** Failure of the Color Vision Test does not require an eye examination, as this problem is **not** correctable.

Thank you for your cooperation. If you have any questions or I can be of assistance, please contact me.

_____
School Nurse/Practitioner

See exam form on next page

SCHOOL HEALTH PROGRAM
REPORT OF EYE EXAMINATION

Student's Name:_____ Date:_____

Visual Acuity: **FAR** **NEAR**

	Right / Left	Right / Left
Without correction:	____ ____	____ ____
With correction:	____ ____	____ ____

Diagnosis or explanation of eye condition:

_____

_____

Plan of treatment:

Glasses prescribed	Yes _____	No _____
Constant Wear	Yes _____	No _____
Near Work Only	Yes _____	No _____
Distance Work Only	Yes _____	No _____
Contact(s) Prescribed	Yes _____	No _____

Recommendation for school:

_____

_____

Return visit:_____

_____
Print Name of Eye Care Specialist

Return report to School Nurse

_____
Signature of Eye Care Specialist

_____
Telephone

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