SCHOOL HEALTH PROGRAM

VISION SCREENING REFERRAL

Name ____ Age _____ Sex ____
Address____
School ___________________________________ Grade _____ Teacher____________________

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. ***Please note:** Failure of the Color Vision Test does not require an eye examination. The findings of the school vision screening test are recorded below:

FINDINGS: SCHOOL VISION SCREENING TESTS

Date ______________________

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

With glasses: Passed ___ Failed ____ Passed ____ Failed ____

Without glasses: Passed ___ Failed ____ Passed ____ Failed ____

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

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

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

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 the school.

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

____
School Nurse/Practitioner

____
Telephone Number

EYE SPECIALIST REPORT

Student's Name ___________________________________ Date: _________________

Visual Acuity:	**FAR** Right/Left	**NEAR** 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