Building Excellence
Health Services

VISION SCREENING FORM

STUDENT'S NAME: _____ **SCHOOL YEAR:** _____

SCHOOL: _____ **GRADE:** _____ **DOB:** _____

INTIAL EXAMINER: _____ **DATE:** _____

Screening Date:			**Examiner:**
	FAR	**NEAR**	**Instrument Used:**
Both Eyes	☐ Pass ☐ Fail	☐ Pass ☐ Fail	**Remarks:** ☐ Within Normal Limits
Right Eye	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Needs Recheck
Left Eye	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Needs Referral
			☐ Wears Glasses

Recheck Date:			**Examiner:**
	FAR	**NEAR**	**Instrument Used:**
Both Eyes	☐ Pass ☐ Fail	☐ Pass ☐ Fail	**Remarks:** ☐ Within Normal Limits
Right Eye	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Needs Recheck
Left Eye	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Needs Referral
			☐ Wears Glasses

Resolution of Problem: _____

_____

If the child cannot be conditioned to traditional vision screening, a functional vision screener may be used.

Date: _____ ☐ **Pass** ☐ **Fail** **Examiner:** _____