REFERAL FOR FOLLOW UP OF SPOT VISION SCREENING

DATE:

STUDENT _____ **D.O.B**_____

SCHOOL _____ **GRADE**_____

Dear Parent or Guardian,

A recent mandated vision screening of students in specific grades was conducted at our school. The screening was conducted by qualified, trained and authorized personnel.

The results of your child's screening indicate that your child should be taken for a complete eye exam by an ophthalmologist or optometrist. Attached is a copy of the results.

Please contact an ophthalmologist or optometrist to schedule an appointment. Take the copy of the results and this notice to the appointment. Have your doctor complete the bottom of this notice and return it to school by Fax or with your student.

If you have questions about the screening and or need more. information about where to take your child for the exam, please feel free to contact your school nurse.

School Nurse

Telephone **Fax Number**

FOR SCHOOL NURSE FROM EYE DOCTOR

1. VISION WITHOUT CORRECTION: OD 20/_____ OS 20/_____
2. VISION CORRECTED: OD 20/_____OS 20/_____
3. ARE GLASSES TO BE WORN AT ALL TIMES?
   YES ___OTHER_____
4. COMMENTS / RECOMMENDATIONS:

DOCTOR'S SIGNATURE_____DATE_____

***PLEASE FAX THIS COMPLETED FORM TO _____ATTN: SCHOOL NURSE**

4/19