

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 _____

1. Visual Acuity:

	Far				Near			
	Right	Left	Passed	Failed	Right	Left	Passed	Failed
With Glasses								
Without Glasses								

2. Convex Lenses (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

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

 Phone Number

SCHOOL HEALTH PROGRAM

EYE SPECIALIST REPORT

Student's Name _____

Date: _____

Visual Acuity:

	Far		Near	
	Right	Left	Right	Left
Without Glasses				
With Correction				

Diagnosis or explanation of eye condition:

Plan of Treatment:

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

Recommendation for school:

Return visit: _____

Print Name of Eye Care Specialist

Signature of Eye Care Specialist

Telephone