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			Right / Left		
With glasses:	___ ___	Passed ___ Failed ____		____ ____	Passed ____ Failed ____	
Without glasses:	___ ___	Passed ___ Failed ____		____ ____	Passed ____ Failed ____	

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

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

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

_____
Telephone Number

SCHOOL HEALTH PROGRAM

EYE SPECIALIST REPORT

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