SCHOOL HEALTH PROGRAM

VISION SCREENING REFERRAL

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 Special Please note: Failure of the Color Vision Test does not require an eye examination. The findings chool vision screening test are recorded below: Chool Screening test are recorded below:	Name			_ Age	Sex
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Date					
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NEAR Right / Left Right / Left Passed Failed Not Tested Passed P			Date		
Right / Left With glasses: Passed Failed Not Tested 8. Color Vision: Passed Failed Not Tested *Eye exam not required. Stereo/Depth Perception: Passed Failed Not Tested *Eye exam not required. Since uncorrected vision disorders can affect learning potential, it is important to have your characteristic 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 cone. School Nurse/Practitioner		_			
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Telephone Number			Telen	hone Num	her

SCHOOL HEALTH PROGRAM

EYE SPECIALIST REPORT

Student's Name		Date:			
Visual Acuity:	<u>FAR</u>		<u>NEAR</u>		
Without correction: With correction:	Right / Left		Right / Left		
Diagnosis or explanation of eye					
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:					
	_				
(Return report to Schoo	ol Nurse)	Print Nar	ne of Eye Care Specia	list	
	_	Signatur	e of Eye Care Special	ist	
	_		Telephone		