SCHOOL HEALTH PROGRAM

EYE SPECIALIST REPORT

Student's Name	Date:		
Visual Acuity:	FAR	NEAR	
Without correction:	Right / Left	Right / Left	
With correction:			
Diagnosis or explanation of eye c			
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:		·	
E			
Return visit:			
	-	Print Name of Eye Care Specialist	
(Return report to Scho	ol Nurse)		
55n	•	Signature of Eye Care Specialist	
		Telephone	

SCHOOL HEALTH PROGRAM



VISION SCREENING REFERRAL

me		Ag	e Sex
ldress	7.4		
hool		radeTeacher	
D 4/Condina			
ar Parent/Guardian:			
We have completed the vision so	reening service pr	ovided as part of the Scho	ol Health Program
1. Communication tock inc	licate the need for	an eve examination by all	Eye Care Speciali
Please note: Failure of the Color V	ision Test does no	t require an eye examman	on. The midnigs o
hool vision screening test are recor	ded below.		
NDINGS: SCHOOL VISION S	CREENING TEST	`S	14
		. Date	
		Date	
Visual Acuity: FAR		NEAR	
Right / Left	Eniled	Right / Left Passed	Failed
With glasses: Passed	Patied	8. 3	
Without glasses: Passec	I Failed	Passed_	Failed
<u> </u>			
- Control Control	1/220	Passed Failed	Not Tested
Convex Lens (excessive farsightedn	.555).		
. Color Vision:		Passed Failed	not required.
<i>Y</i>		Eye exam	not required.
. Stereo/Depth Perception:		Passed Failed	Not Tested
i j			
Comments:			
Since uncorrected vision disord	ders can affect lear	ning potential, it is import	ant to have your c
	the back of	This letter and renim IC to	the school.
Thank you for your cooperation	n. If you have any	questions of 1 can be of a	issistance, picase c
ne.		m. X. 1	1/20.11
		11/ks-1 reste	ne ///CClo
1		School Nu	rse/Practitioner
		774.2/0/0	-2833 x
		Telepho	one Number
		Totobu	