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| **School District Name Here** |

**VISION SCREENING PARENT/GUARDIAN NOTIFICATION OF RESULTS AND REFERRAL**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_\_\_\_ Date: ­\_\_\_\_\_\_\_\_\_\_

Student Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Parent/Guardian:

🞏 Your child was screened for vision at school and no issues were noted.

🞏 Your child was screened for vision at school, he/she had some trouble reading the charts. Screening results do not

always mean there is a problem. Please have your child’s eyes examined by an eye care professional and ask them to

complete this form. Return the completed form to the school as soon as possible.

🞏 Staff observations attached.

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| **School Vision Screening Results:** | | |
| **Vision Test** | **With Lenses** | **Without Lenses** |
| Distance Vision Acuity | Right Eye 20/\_\_\_\_\_\_\_ | Right Eye 20/\_\_\_\_\_\_\_\_ |
|  | Left Eye 20/\_\_\_\_\_\_\_ | Left Eye 20/\_\_\_\_\_\_\_\_ |
| Near Vision Acuity | Right Eye 20/\_\_\_\_\_\_\_ | Right Eye 20/\_\_\_\_\_\_\_\_ |
|  | Left Eye 20/\_\_\_\_\_\_\_ | Left Eye 20/\_\_\_\_\_\_\_\_ |
| Color Perception | 🞏 Pass 🞏 Fail | |
| Optional:Hyperopia Screening | 🞏 Able to see 20/\_\_\_\_\_\_\_ with diopter lens strength + \_\_\_\_\_\_ | |
| **School Health Professional**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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| **Report of Professional Eye Examination to the School**  **Date of examination**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Corrected Visual Acuity Right 20/\_\_\_\_\_\_ Left 20/\_\_\_\_\_\_** | | |
| **Vision Test** | **With Lenses** | **Without Lenses** |
| Distance Vision Acuity | Right Eye 20/\_\_\_\_\_\_\_ | Right Eye 20/\_\_\_\_\_\_\_\_ |
|  | Left Eye 20/\_\_\_\_\_\_\_ | Left Eye 20/\_\_\_\_\_\_\_\_ |
| Near Vision Acuity | Right Eye 20/\_\_\_\_\_\_\_ | Right Eye 20/\_\_\_\_\_\_\_\_ |
|  | Left Eye 20/\_\_\_\_\_\_\_ | Left Eye 20/\_\_\_\_\_\_\_\_ |
| Color Perception | Results if Fail: | |
| Optional**:** Hyperopia Screening | Able to see 20/\_\_\_\_\_\_\_ with diopter lens strength + \_\_\_\_\_\_ | |
| Peripheral vision, if fields are restrictive, indicate degree and location: | | |
| Diagnosis: | | |
| Plan: 🞏No Treatment at this time 🞏Eyeglasses 🞏Contact Lenses 🞏 Patch 🞏 Other: | | |
| Frequency of use: 🞏 Wear at all times 🞏 For distance only 🞏For reading tasks only 🞏Other: | | |
| Physical Education: 🞏 Wear for Physical Education 🞏 Remove for Physical Education | | |
| **Medical Provider:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Signature) (Phone) (Date) | | |
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**For school use:**

🞏 Completed form received on date: \_\_\_\_\_\_\_\_\_\_\_\_

🞏 Completed form not returned to school

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| Sample resource created by NYS Center for School Health located at [www.schoolhealthny.com](http://www.schoolhealthny.com) 5/2018 |