Office of the School Nurse

VISION SCREENING REFERRAL

Date: ___________________

SUBJECT: Vision Screening Referral

TO: Parents of _________________________________

1. Your child's vision has been checked by school health officials and the findings indicate:

_____ your child should be scheduled for a complete examination at the *eye clinic.*

_____ children wearing glasses are recommended to have a yearly eye examination.

(*Please take this form with you to the appointment)*

2. For an appointment parents should call:

Return the form completed by the physician to the school nurse.

3. If you have any questions concerning the screening results or any problem getting an appointment please contact "insert name and school number".

4. Screening results: with/without glasses:

Distance: Right 20/__________ Left 20/___________________

Near: Right 20/__________ Left 20/___________________

Comments:____

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INFORMATION TO SCHOOL NURSE FROM OPTOMETRY CLINIC

1. Vision without glasses: OD 20/______ OS 20/______
2. Vision corrected to: OD 20/______ OS 20/______
3. Ocular health: ______Normal ______ Abnormal
4. Extraocular muscle balance: ______Normal ______ Abnormal
5. Heterophoria/Heterotropia: No Deviation Deviation

Comments:____

6. Are glasses to be worn at all times? Yes No
7. Specific recommendations (reading glasses only, etc.) ____________________________
8. Future clinic appointment date? ____

____

Examiner/Date

1) Original to Physician 2)Copy returned to school nurse 3) Copy for student file