

Alachua County Public Schools
Health Services
Optometrist/Physician Report for Vision

Student Name: _____ Date of Screening: _____

School: _____

School Screening Results: Letters or symbols

Right Eye 20/_____ Left Eye 20/_____

No Glasses/Contacts Glasses Contacts Glasses Broken/Lost

Physician:

This child was identified as having vision difficulties through a routine school screening program. Please complete the form outlined below. This information will help to evaluate the effectiveness of the program. Thank you for your cooperation.

Parent/Guardian: Please return this form after Optometrist/Physician examination to the school nurse.

If you need assistance or have any questions, please contact:

School Nurse

Phone Number

Below to be completed by Optometrist/Physician

Please check the appropriate answer:

- This student was evaluated and found not to have a problem.
- This student was evaluated and thought to have vision difficulties. Student received corrective _____.

School Limitations:

- None; student can fully participate in school and activities.
- School limitations are: _____

Optometrist/Physician's Signature / Phone

Date