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