SCHOOL HEALTH PROGRAM VISION SCREENING REFERRAL FORM

NAME: _____

AGE: _____ **SEX:** _____

ADDRESS: _____

SCHOOL: _____

TEACHER: _____ **GRADE:** _____

Dear Parent,

We have completed the vision screening service provided as part of the School Health Program. Results of your child's vision screening indicate the need for a more complete eye examination.

Since uncorrected vision disorders can affect learning potential, it is important to complete this referral and return it to the school when completed.

Thank you for your cooperation. If you have any questions, or if I can be of service, please contact me.

_____ _____

School Nurse/School Health Coordinator *Telephone*

Please Return Form To: _____

_____

_____

_____

EXAMINATION RESULTS:

_____ Normal Exam _____ Amblyopia _____ Muscle Imbalance

_____ Refractive Error Other _____

_____ Myopia
_____ Hyperopia
_____ Astigmatism

Treatment _____ Return Advised? _____ When? _____

Doctor's Name: _____ Date _____

Address: _____

_____