

SAMPLE

<District/School Name or Letterhead>
Vision Referral Letter

Date _____

Dear Parent/Guardian:

Recent vision screening test at school indicates that _____ may have some vision
(student and grade)
difficulty. A comprehensive eye examination is recommended. Please take this form with you at the time of
examination.

(School Nurse)

(School Contact information)

REASON FOR REFERRAL

Vision Test Results _____ Screening Tool(s) used*: _____

- Blinking Blurred Vision Frequent headaches after reading
- Squinting Watering Eyes Other _____

Remarks _____

* If an automated screening was used, attach printout from the machine.

EYE EXAMINER’S REPORT TO SCHOOL

Diagnosis: _____

- No Treatment Indicated
- Treatment Recommended
 - Glasses Prescribed
 - To be worn at all times
 - To be worn at all times except during physical education
 - To be worn for far vision activities, e.g., driving, looking at the board
 - To be worn for near vision activities, e.g. computer work, reading, writing Other: _____

Vision to be expected with correction: R 20/ L 20/

Classroom/School Recommendations: _____

Recommended Date for Re-examination: _____

We would appreciate any additional information which may be pertinent to this student’s school adjustment.

Date _____

Name of Eye Examiner (MD, DO, or OD)

Phone/Email _____

Signature of Eye Examiner

NOTE: Please complete and return to the school nurse. Thank you.