



Iowa Department of Public Health

CERTIFICATE OF VISION SCREENING

Pursuant with Iowa Code Chapter 641.52

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent/Guardian Telephone Number:	Student Address:	
Zip Code:		

Screening Information vision testing requirements can be accomplished either through a screening (see below) or with a comprehensive eye exam (see other side). Screening provider must complete this section *or parents may attach a copy of vision screening results given to them by a provider.*

Date of Vision Screening: _____
Result: (Please check): <input type="checkbox"/> Pass or <input type="checkbox"/> Fail
Testing method: (Please check) <input type="checkbox"/> Vision Screening <input type="checkbox"/> Photo Screen <input type="checkbox"/> Other: _____
Visual Acuity: (if available) <input type="checkbox"/> With Correction <input type="checkbox"/> Without Correction
Right Eye _____ Left Eye _____
Referral to eye health professional: (Please check) <input type="checkbox"/> Yes or <input type="checkbox"/> No

Business Name/Source of Screening: (please print name of provider office or if provided by school nurse, name of school)

Provider Name: (please print) _____ Phone: _____

Signature and Credentials
of Provider: _____ Date: _____

A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten **and** again before enrollment in the 3rd grade.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in Kindergarten and 3rd grade and no later than six months after the date of the child's enrollment in Kindergarten and 3rd grade.

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Eye Exam Section

Pursuant with Iowa Code Chapter 280.7A

To the Parent or Guardian: The Iowa Optometric Association strongly recommends that to fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. **If you choose to** take your child to an eye care professional for a comprehensive eye exam, this side of the form should be filled out and signed by the eye care professional and returned to the school nurse or teacher by your child.

Visual Acuity

At Distance

At Near

- | | | | | |
|--|------|------|------|------|
| <input type="checkbox"/> Without correction | R20/ | L20/ | R20/ | L20/ |
| <input type="checkbox"/> With present correction | R20/ | L20/ | R20/ | L20/ |
| <input type="checkbox"/> With new correction | R20/ | L20/ | R20/ | L20/ |

External Eye Health

Internal Eye Health

- | | | | |
|---------------------------------|--------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Other | <input type="checkbox"/> Normal | <input type="checkbox"/> Other |
|---------------------------------|--------------------------------|---------------------------------|--------------------------------|

Vision Analysis

R L

- | | | | |
|--------------------------|--------------------------|------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Normal eyesight | <input type="checkbox"/> Eye teaming difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> | Nearsighted (myopia) | <input type="checkbox"/> Crossed-eyes (strabismus) |
| <input type="checkbox"/> | <input type="checkbox"/> | Farsighted (hyperopia) | <input type="checkbox"/> Eye focusing difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> | Astigmatism | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> | <input type="checkbox"/> | Amblyopia | |

☐ Other _____

Vision Correction Recommendations

- | | | |
|--|---|---|
| <input type="checkbox"/> No correction necessary | To be worn for: | |
| <input type="checkbox"/> No change in present prescription | <input type="checkbox"/> Constant wear | <input type="checkbox"/> Near vision only |
| <input type="checkbox"/> New prescription needed | <input type="checkbox"/> Distance vision only | <input type="checkbox"/> As needed |

To the Eye Care Professional: Please sign and date this form after the examination.

Dr. Name (Please Print) _____

Date _____ Signature _____