Burrell School District
Vision Screening Referral

Name _____ Grade_____

Date _____ Homeroom_____

Dear Parent/Guardian:

Vision screening service provided as part of the School Health Program has been completed on your child. Results of your child's vision test indicate the need for an eye examination by an Eye Care Specialist. Please request the examiner to complete the reverse side of this letter. **Return the completed form to your child's school nurse by _____. *Please note:** Failure of the Color Vision Test does not require an eye examination. The findings of the school vision-screening tests are recorded below:

FINDINGS: SCHOOL VISION SCREENING TESTS

1. Visual Acuity: **FAR** **NEAR**

	Right/ Left	Right/Left
With glasses:	___ ___	___ ___
Without glasses:	___ ___	___ ___

2. Convex Lens (excessive farsightedness): Passed ___ Failed___ Not Tested___

3. Color Vision Passed ___ *Failed___ Not Tested___
*Eye exam not required.

4. Stereo/Depth Perception: Passed ___ Failed___ Not Tested___

Comments:_____
_____
_____

Since uncorrected vision disorders can affect learning potential, it is important to have your child's Eye Care Specialist complete the form on the back of this letter and return it to the school.

Thank you for your cooperation. If you have any questions, please contact your child's school nurse. Many resources are available if you need assistance in getting an eye exam or glasses for your child.

_____
Certified School Nurse

Burrell School District
Vision Screening Referral

Name _____

Visual Acuity:	**FAR**	**NEAR**
	Right/ Left	Right/Left
With glasses:	___ ___	___ ___
Without glasses:	___ ___	___ ___

Diagnosis or explanation of eye condition:

_____

_____

Plan of Treatment:

Glasses Prescribed	Yes ____	No____
Prescription Change	Yes ____	No____
Constant Wear	Yes ____	No____
Near Work Only	Yes ____	No____
Distance Work Only	Yes ____	No____
Contacts Prescribed	Yes ____	No____
Best Correction	Yes ____	No____

Recommendation for school:

_____

_____

_____
Exam Date

(**Return report to School Nurse)**

_____
Signature Eye Care Specialist

My child's school nurse may contact the eye care specialist named above to clarify any questions concerning my child's vision.

_____
Parent Signature