UNIONTOWN AREA SCHOOL DISTRICT

VISION REFERRAL FORM

DATE: ____________________

Dear Parent/Guardian:

Your child, _________________________ did not pass the vision screening test given at ____________________ School on _________________________. This indicated that he/she may have a vision defect and we recommend that he/she have an eye examination as soon as possible. Please request that the examiner complete the form below.

If your child has had a recent eye examination, please request that the examiner record the results of the examination and return the form to the school nurse. Thank you.

School Nurse

Please return to the School Nurse.

School: ______________________

Child's Name: ____________________ Grade: _____ Teacher: _______________

Diagnosis: ____

Visual Acuity: Without Lenses Right eye ___ Left eye ___ Both ___

With Lenses Right eye ___ Left eye ___ Both ___

Glasses prescribed for constant wear _____ for reading _____ no Rx. _____

When should child be rechecked? ____

Should activities be limited because of eye condition? Yes _____ No _____

Other recommendations: ____

____

Date: ______________________ Physician: ______________________________

jjm