Print Form

Vision Screening Referral

Health Services
Mat-Su Borough School District
501 N. Gulkana
Palmer, AK 99645
P: (907) 746-9200

Date: _____ ***School:*** _____ ***Grade:*** _____

Dear Parent/Guardian of:

DOB: _____ **Name:** _____

As a part of our school health program, each student has periodic vision screening. The most recent screening indicates a need for your child to have a more thorough examination by an optometrist or ophthalmologist.

Your child's results were:

Acuity Screening	Both	Right	Left
Without Glasses	20/	20/	20/
With Glasses	20/	20/	20/
Near Point Vision	20/	20/	20/

Your child should have a vision exam as soon as possible. Please take this form with you and request that the lower part be filled out and returned to the school for your child's health record. If your child had a vision exam in the last 12 months, fill out the Parent's report section and return it to the school.

_____ _____

Phone Number School Nurse Signature

PARENT'S REPORT OF EYE CARE

Date of most recent exam_____ Dr. /Clinic _____
Name_____
Glasses: ☐ Yes ☐ No Full or Part time use? _____ other treatment_____
Additional Comments _____

_____ _____

Date Parent/Guardian Signature

EXAMINER'S REPORT TO THE SCHOOL

The following information will be helpful to the school nurse and the teacher. Please complete this form and return to the school.
Visual acuity:

Without lenses	With present lenses	With best correction
RE	RE	RE
LE	LE	LE

Wear Glasses: ☐ Yes ☐ No _____Constantly _____In class _____Reading only
Diagnosis, suggestions and restrictions as to class seating, prognosis, or special treatment:

_____
_____

_____ _____

Date Examiner's Signature

_____ _____

Phone Number Examiner's Printed Name