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**East Stroudsburg Area School District
East Stroudsburg, Pennsylvania 18301**

VISION SCREENING REFERRAL

Student Name: _____ Grade/Homeroom: _____
Date: _____

Dear Parent/Guardian:

We have completed the vision screening service provided as part of the School Health Program. Results of your child's vision screening indicate the need for an eye examination by an Eye Care Specialist. The findings of the school vision screening are recorded below:

*Please note: Failure of the Color Vision Test doesn't require an eye examination.

1. Visual Acuity:	FAR	NEAR
	Right/Left	Right/Left
With Glasses	___/___ Pass___ Fail___	___/___ Pass___ Fail___
Without Glasses	___/___ Pass___ Fail___	___/___ Pass___ Fail___

2. Convex Lens (excessive farsightedness: Pass___ Fail___ Not Tested___
3. Color Vision Pass___ Fail___ Not Tested___
*Eye Exam Not Required
4. Stereo/Depth Perception: Pass___ Fail___ Not Tested___

Comments: _____

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

Thank you for your cooperation. If you have any questions or if I can be of assistance, please call.

School Nurse

Phone Number

EYE SPECIALIST REPORT

Student's Name _____ Date _____

Visual Acuity:

FAR

NEAR

	Right	Left	Right	Left
Without Correction	_____	_____	_____	_____
With Correction	_____	_____	_____	_____

Diagnosis or explanation of eye condition:

Plan of Treatment:

Glasses Prescribed	Yes _____	No _____
Constant Wear	Yes _____	No _____
Near Work Only	Yes _____	No _____
Distance Work Only	Yes _____	No _____
Contact(s) Prescribed	Yes _____	No _____

Recommendation for school:

Return visit: _____

Signature of Eye Care Specialist

Print Name of Eye Care Specialist

Address

Telephone

RETURN REPORT TO SCHOOL NURSE