Vision Screening & Referral Form

School Nurse Name: ___________________________

Phone # _____________________________________

Fax# ____

Student Name: ______________________________________

DOB: ____________________ Grade: ____________________

School: ______________________ Fax#___________________

Dear Provider:
Below are the results of the school vision screening on the student named above. Please complete the Eye Care Specialist Report and return the completed form to the school nurse listed above. A request is also made that you provide the parent/guardian with a copy of the report.

School Screening Report

1st Date screened ________________	☐ With correction	☐ Without correction	2nd Date Screened __________________	☐ With correction	☐ Without correction
Distance Visual Acuity: R 20/_____ L 20/_____			**Distance Visual Acuity:** R 20/_____ L 20/_____		

Ocular Alignment (Random Dot E/Stereotest)	**Color Vision**	**Clinical Observation Notes**
☐ Pass ☐ Fail ☐ Did Not Test	☐ Pass ☐ Fail ☐ Did Not Test	

Eye Care Specialist Report

Date of Exam:	**Overall Findings:** ☐ Normal exam, no glasses needed ☐ Significant refractive error, glasses needed	☐ Strabismus ☐ Amblyopia ☐ Other (please specify):_________________

Distance Visual Acuity:

Without Correction	With Current Prescription	With New Prescription
R_________ L_________	R_________ L_________	R_________ L_________

Cycloplegic refraction is recommended for all children.
Agent used: ☐ Cyclopentolate ☐ Tropicamide ☐ None

Was a prescription for glasses given? ☐ Yes ☐ No

	Cycloplegic Refraction			Vision	Glasses Prescription Given		
	Sphere	Cylinder	Axis		Sphere	Cylinder	Axis
OD							
OS							

Do you need to see this child again? __________ When?________________________________

Recommendations (other than glasses):
☐ Patching ☐ Atropine drops ☐ Referral to pediatric specialist ☐ Other (specify):__________________________________

Eye Specialist: ____ Date: ____

Office Phone Number: ______________________________ Office Address: ____