

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:                          | <b>FAR</b>                            | <b>NEAR</b>             |
|  | 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:	<b>FAR</b>	<b>NEAR</b>
	Right/ Left	Right/Left
With glasses:	___ ___	___ ___
Without glasses:	___ ___	___ ___

Diagnosis or explanation of eye condition:

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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:

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**(Return report to School Nurse)**

\_\_\_\_\_  
Exam Date

\_\_\_\_\_  
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