PITTSYLVANIA COUNTY SCHOOLS
P.O. Box 232 • 39 Bank Street S.E. • Chatham, Virginia 24531

VISION SCREENING

Student's Name _____

School _____ Grade _____ Teacher _____

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TO BE COMPLETED BY CLASSROOM TEACHER:

Dear Parent/Guardian:

Your child has exhibited the following behaviors, which indicate a possible vision problem:

_____ Squints, blinks or rubs eyes excessively.
_____ Complains of headaches, nausea or dizziness after close work.
_____ Holds body tense when reading or concentrating visually.
_____ Thrusts head or body forward to see.
_____ Covers or closes one eye to read.
_____ Tilts head to read.
_____ Loses place on page, skips words, or reads same words twice.
_____ Is inattentive to board work, charts, or maps.
_____ Stops reading after brief period.
_____ Reverses or confuses words, syllables or letters.
_____ Verbally expresses difficulty seeing.

Comments: _____

_____

With your permission, our school nurse can perform a vision screening. Please complete the next section of this form and return it to me.

_____ _____
Date Teacher's Signature

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TO BE COMPLETED BY PARENT/GUARDIAN:

_____ I give my permission for my child to be given a vision screening by the school nurse

OR

_____ I do not give my permission for my child to be given a vision screening by the school nurse.

Comments: _____

_____

_____ _____
Date Parent's Signature

TELEPHONE NUMBERS: (434) 432-2761 • (434) 793-1624 (Danville) • (434) 656-6248 (Gretna) • FAX (434) 432-9560

TO BE COMPLETED BY THE SCHOOL NURSE:

Your child's vision was checked at school today and the following results obtained:
_____ Vision is found to be normal.
_____ Even though your child wears glasses, a deficit still exists. Check with your child's optometrist/ophthalmologist to see if this is the best correction achievable at this time.
_____ A prompt professional examination is needed because he/she had a problem with the following: _____ far vision
_____ near vision
_____ weakness in the muscles of the eye and potential for blurring and double vision
_____ color discrimination

Comments: _____
_____

If your child receives free or reduced lunch and does not have Medicaid benefits, you may qualify for financial assistance with the eye exam and the purchase of glasses (if prescribed). Please call me at one of the telephone numbers listed below if you need assistance or have any questions.

_____ _____
Date School Nurse Signature

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TO BE COMPLETED BY VISION PROFESSIONAL:
PHYSICIAN'S FINDINGS AND RECOMMENDATIONS:

_____
Student's Name

_____ No significant findings at this time
_____ Correction necessary and prescribed
_____ Referred to consultant for further evaluation

Comments: _____
_____
_____

_____ _____
Date Physician (Please Print)

_____
Physician's Signature

RETURN COMPLETED FORM TO SCHOOL NURSE FOR DOCUMENTATION AND FILING