

VISION SCREENING

Student's Name _____

School _____ Grade _____ Teacher _____

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

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

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

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

Telephone Number: (434) 432-2761 (Chatham) – (434) 793-1624 (Danville) – (434) 656-6248 (Gretna) – Fax: (434) 432-2893