STILLWATER AREA SCHOOLS

VISION REFERRAL FORM

Student's Name:_____

Dear Parent:

Your child's vision was screened at school on _____.

Students were re-screened on _____.

Although the results do not definitely mean that glasses or other treatments are needed, it is urged that you take your child for a thorough professional eye examination for the reason checked below:

[ ] Possible muscle imbalance

[ ] Vision acuity on HOTV chart for K through 1st grade Vision R 10/ L 10/ (with) (without) glasses

[ ] Vision acuity on Snellen chart for 1st through 12th grade R 20/ L 20/ (with) (without) glasses

[ ] Possible farsightedness

Please take this form with you when your child is examined and ask the examiner to complete below and send it back to the school health room. This form is important for the health room to be able to follow up on their records and your children's needs.

School Nurse:_____ Address:_____

Phone:_____ Health Office Phone:_____ Fax:_____

Dear Eye Office Examiner:

Please complete this form and return at your earliest convenience to the school nurse listed above:

I feel his/her eye problem is:

[ ] Not sufficient to require treatment
[ ] Fully treatable
[ ] Partially treatable
[ ] Not treatable
[ ] Glasses Prescribed Best Correction: R Eye 20/_____ L Eye 20/_____

Vision Defect:

[ ] Muscular
[ ] Myopia
[ ] Hyperopia
[ ] Astigmatism
[ ] Other (Please specify) _____

I expect that on completion of whatever treatment is necessary, there will be:

[ ] No significant vision handicap that may interfere with learning
[ ] Visual handicap that may interfere with learning

Special Recommendations: _____

Examiner's Signature _____

Date _____