

SCHOOL HEALTH PROGRAM

NOTICE REGARDING ANNUAL VISION SCREENING TEST

Pupil's Name \_\_\_\_\_ Date \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

TO PARENT OR GUARDIAN:

...that every child may have some eye difficulty. A complete eye examination is recommended to determine the need for professional care. This should be returned to the nurse.

TO THE EXAMINER:

Your diagnosis and recommendations will be appreciated and will assist in planning this child's school program.

SCHOOL OBSERVATIONS:

TEST RESULTS: Visual Acuity

TEST USED: New York Vision Tester

Distance: R: 20/ \_\_\_\_\_ ; L: 20/ \_\_\_\_\_

Near: \_\_\_\_\_

\_\_\_\_\_  
School Nurse

EXAMINER'S DIAGNOSIS AND RECOMMENDATIONS:

Date of examination \_\_\_\_\_ 200\_\_\_\_\_

1. Diagnosis: R- \_\_\_\_\_  
L- \_\_\_\_\_

Acuity Correction L20/ \_\_\_\_\_ Correction L20/ \_\_\_\_\_

3. Are glasses to be worn? Yes \_\_\_\_\_ No \_\_\_\_\_

4. If yes indicate extent of use \_\_\_\_\_

5. Interscholastic sports: if student's uncorrected vision is 20/200 or worse in either eye is student able to participate in contact sports? Yes \_\_\_\_\_, No \_\_\_\_\_

EXAMINER'S SIGNATURE

EXAMINER'S STAMP: