Southeast Delco School District

Educational Service Center
1560 Delmar Drive, Folcroft, Pa. 19032 • (610) 522-4300 • Fax (610) 532-4947

VISION SCREENING REFERRAL

Name_____ Date_____

School_____ Grade_____

Dear Parent/Guardian:

We have completed the vision screening service provided as part of the School Health Program. Results of your child's vision test indicate the need for an eye examination by an Eye Care Specialist. ***Please note:** Failure of the Color Vision Test does not require an eye examination. The findings of the school vision-screening test are recorded below:

FINDINGS: **SCHOOL VISION SCREENING TESTS**

1. Visual Acuity: **FAR** **NEAR**

	Right/Left		Right/Left	
With glasses:	___ ___	Passed___Failed___	___ ___	Passed___Failed___
Without glasses:	___ ___	Passed___Failed___	___ ___	Passed___Failed___

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 or I can be of assistance, please contact me.

_____ _____

School Nurse/Practitioner Telephone Number

SCHOOL HEALTH PROGRAM

EYE SPECIALIST REPORT

Name_____ Grade ____ Date_____

Visual Acuity:	**FAR**	**NEAR**
	Right/Left	Right/Left
Without correction:	____ ____	____ ____
With correction:	____ ____	____ ____

Diagnosis or explanation of eye condition:

_____

_____

_____

Plan of Treatment:

Glasses Prescribed	Yes____	No____
Constant Wear	Yes____	No____
Near Work Only	Yes____	No____
Distance Work Only	Yes____	No____
Contact(s) Prescribed	Yes____	No____

Recommendation for school:

_____

_____

_____

Return visit:_____

_____
Print Name of Eye Care Specialist

(Return report to School Nurse)

_____
Signature of Eye Care Specialist

_____
Telephone Number