**Warren County Schools**
**School Health Services**

## Vision – Referral for Professional Exam

| **Student** | | | | Parent<br>Legal Guardian |
|---|---|---|---|---|
| Date of Birth | | | | |
| School | School Year | Bus | Car | Cell Phone<br>Work Phone<br>Home Phone |
| Teachers<br>Grade | | | | |

Dear Parent/Legal Guardian: **Date of Referral: _____ / _____ / _____**

An accurate measurement of your child's visual acuity cannot be obtained using standard school screening methods. It is recommendation that a vision specialist evaluate your child. Please make an appointment with a professional eye care provider. **Take this form with you and have the examiner complete the bottom portion. Please return this entire form to the school nurse.**

Comments: _____

If you have questions or need assistance, contact me at school. Leave a message including your name, child's name, and a number where you can be reached during school hours.

Thank you,

School Nurse

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**Examiner, please complete.** **Date of Examination: _____**

Glasses / Contacts prescribed: _____ Yes _____ No _____ Best Correction in place

Glasses / Contacts ordered today: _____ Yes _____ No _____ Preferential seat needed

Glasses / Contacts Ready for Pickup: _____

**Visual Acuity:** Uncorrected Far R 20/_____ L 20/ _____ Near R 20/ _____ L 20/ _____
**Findings:** with correction Far R 20/_____ L 20/ _____ Near R 20/ _____ L 20/ _____

**Glasses to be worn:** ___at all times ___for all school work ___Distance-boardwork ___Near-reading

Vision Diagnosis: _____

Return to Eye Doctor in _____ months.

Suggestions/Remarks: _____

Include any special accommodations _____

Needed for this student at school _____

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_____ _____ Date: _____
Examiner's Signature Print Name

Phone #: _____ Fax #: _____