Health Services **Vision Referral Form**

Name: ______________________ DOB:__________ Student ID#: ____________________

Campus: ______________________ Grade:________ Date: ____________________

Dear Parent: Vision screenings were recently completed for your child's class. The results of the screening reveal that your child may have difficulty seeing. Please schedule an appointment with an eye care specialist as soon as possible for further evaluation. After the specialist has evaluated your child and completed this form, please return the top copy to the nurse.

If your child is already receiving care for this problem, please sign the waver of referral at the bottom of this form and return it to the school nurse. If you have any questions about our screening program or how to obtain further vision services, please contact me.

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School Nurse

Distance Acuity Screen:

First Screen	**Date:** ___________	**Second Screen**	**Date:** __________
With Correction	Yes ☐ No ☐	With Correction	Yes ☐ No ☐
	Chart Used		Chart Used
	Letter ___________		Letter ___________
Right Eye 20/ _____	NGM ___________	Right Eye 20/ _____	NGM ___________
	HOTV ___________		HOTV ___________
Left Eye 20/ _____	Machine ___________	Left Eye 20/ _____	Machine ___________
	Tumbling E ________		Tumbling E ________
	Symbol___________		Symbol___________
Pass ☐ Fail ☐		Pass ☐ Fail ☐	

HIRSCHBERG CORNEAL LIGHT REFLEX:	**COVER-UNCOVER TEST:**
Right Eye: Left Eye:	**NEAR:** ☐ **No Movement** Right Eye: Left Eye: **FAR:** ☐ **No Movement** Right Eye: Left Eye:
(Put an X where the light falls on eye)	(With an arrow, show the direction the eye moved, if it moved)

REFERRAL TO EYE CARE SPECIALIST (OPHTHALMOLOGIST OR OPTOMETRIST) DUE TO:

☐ Distance Acuity Test	☐ Cover-Uncover Test	☐ Observable Signs or Symptoms
☐ Plus Lens Test	☐ Unscreenable	☐ Light Reflex Test
☐ Hirschberg-Corneal	☐ Parent/M.D. Request	☐ Other______________________

Comments ______________________________ Name of Screener ______________________

Physician, please complete the following:

Results: ____

Recommendations: ____________________________________

Comments: ____

______________________________ ______________________________

Signature Title

______________________________ ______________________________

Printed Name Date

Return completed referral to school nurse

WAIVER OF REFERRAL

My child,______________________ , is already under an eye specialist's care for the problem(s) indicated.

______________________________ ______________________________

Parent's Signature Date

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