Valley School District No. 070
3030 Huffman Road • Valley, WA 99181 • Ph: (509) 937-2791 • Fax: (509) 937-2204 • www.valleysd.org

Referral for Vision Examination

Report to Parents/Guardians

Dear _____ Date:_____

The results of a vision screening for your child at school indicate a need to have a professional eye examination. Normal vision is considered to be 20/20. Rescreening by a vision specialist is recommended when a child is unable to see clearly at 20/32 or higher. Your child's vision screening results are listed below:

Student Name _____ Birthdate _____ Grade _____
Last First Middle Initial m / d / y

Date of Screening:	☐ **VISUAL ACCUITY WITHOUT GLASSES/CONTACTS**	☐ **VISUAL ACCUITY WITH GLASSES/CONTACTS**
Comments:	RIGHT EYE:	RIGHT EYE:
	LEFT EYE:	LEFT EYE:
	BOTH EYES:	BOTH EYES:

Please take this form to your child's professional eye examination appointment and ask the eye care specialist to provide the information in the form section, below. Please return this completed form to the attention of the school nurse in the school office. (*Keep a copy for your records.*)

If you need assistance finding an eye care specialist to do the examination or have any other questions, please contact me at (509) 937-2830 or schoolnurse@valleysd.org. Thank you for your prompt attention to this request and for recognizing the importance of your child's visual health to his/her academic success.

Sincerely,

Renae Fitzgerald, RN
Valley School District Nurse

EYE CARE SPECIALIST – REPORT TO SCHOOL NURSE

STUDENT NAME: _____

☐ VISUAL ACCUITY WITHOUT GLASSES/CONTACTS: RIGHT EYE_____ LEFT EYE_____

☐ VISUAL ACCUITY WITH CURRENT GLASSES/CONTACTS: RIGHT EYE_____ LEFT EYE_____

DIAGNOSIS / COMMENTS: _____

_____

CORRECTION NEEDED: ☐ NO ☐YES
☐ GLASSES ☐ CONTACTS ☐ CONSISTENT WEAR ☐ CLOSE WORK ☐ DISTANCE

PROFESSIONAL RE-EXAMINATION RECOMMENDED BY (DATE): _____

Eye Care Specialist:

Name / Office: _____ Date of Exam: _____

Signature: _____ Phone No.: _____