



Report of School Vision Screening

(This form is approved by the Superintendent of Public Instruction by Education Code Section 49456, for reporting results of vision screening to parents and guardians and for obtaining recommendations from the professional examiner.)

Date Screened: _____

Dear Parent/Guardian:

Your student, _____, received a vision screening at school. Grade: _____

The following results were obtained:

Optotype test: Far Vision right eye: 20/____ left eye 20/____

Near Vision right eye: 20/____ left eye 20/____

Additional procedures: Tracking Convergence 3D Stereopsis

Plus lenses Near pt with Lea symbols @ 16" Color Vision

Comments: _____

It is recommended that your child's eyes be examined by an eye or vision practitioner.

It is requested that you take this form with you, have it completed by the examiner, and then return it to your school's health office.

Name of School _____ Phone _____

Trinity County School Nurse

Report of Vision Exam to the School					
Name of Student		School	Grade	Date Examined	Date of Reexamined
Visual Acuity		Lens Requirements			
<i>Without lens</i> R 20/____ L 20/____	<i>With lens</i> R 20/____ L 20/____	Results <input type="checkbox"/> Correction not required for the right eye <input type="checkbox"/> Correction not required for the left eye <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lens		Frequency <input type="checkbox"/> Wear at all times <input type="checkbox"/> Wear for close work <input type="checkbox"/> Wear for distance only	
Diagnosis			Recommendations (special seating, large print, when to return for follow-up care)		
Examiner's signature		Address		Phone Number	

I give permission to share this information with the school.

(Parent/Guardian's Signature)