Must be Returned to the School Nurse

Stroudsburg Area School District
123 Linden Street
Stroudsburg, PA 18360
Vision Referral and Report Form

Dear Parent/Guardian:

Your child, _____, grade _____
is being referred for a professional vision examination because he/she did not perform satisfactorily on our school vision screening test. Since these tests are not diagnostic and only measure limited areas of vision performance, we feel a complete professional vision examination is warranted. We believe that your child will benefit by giving this matter your attention as soon as possible.
Please take this form to your child's eye doctor. Thank you for your cooperation.

Date Screened: _____ School Nurse Signature _____
Address _____
Phone _____

Dear Doctor:

The above named child did not perform satisfactorily on our school vision screening test. Our observations indicate the possibility of visual difficulty in the following area(s) checked:

Visual acuity with/without lenses: _____stereo depth perception_____
Amblyopia: _____
Color vision: _____
Muscle Balance: _____
Convex Plus Lens: _____
Student comment: _____
Teacher comment: _____

Please complete and return this form to the school nurse with your findings and recommendations as soon as possible. Thank you.

EYE EXAMINER'S REPORT

Visual Acuity: without lenses RE _____ LE _____ Both _____
with lenses RE _____ LE _____ Both _____

Eye Health: _____

Refractive Error: _____

Color Vision: _____

Accommodation: _____

Muscle Coordination: _____

Other: _____

Were glasses prescribed? Yes _____ No _____

Glasses should be worn: Constantly _____ Reading only _____ Other _____

Other recommendations: _____

Date _____ Signed: _____

Print name: _____

Address: _____

Telephone: _____

Revised: 7/2000