

GREAT NECK PUBLIC SCHOOLS

Health Services

Vision Referral Update

Date \_\_\_\_\_

Name \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Dear Parent:

The results of the school vision screening are below. An annual eye exam is highly recommended by your physician as eye conditions may change from year to year. The results of this examination will assist school personnel in making all necessary modifications to your child's educational program.

**Without Correction:**

**With Correction**

Distance Acuity: Right Eye 20/ Left Eye 20/ Right Eye 20/ Left Eye 20/

Near Acuity: Right Eye 20/ Left Eye 20/ Right Eye 20/ Left Eye 20/

\_\_\_\_\_  
School Nurse

**On your next visit, this form should be completed by the examining physician and returned to the school nurse.**

Date of Examination \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Visual Acuity:

Without Correction: Right Eye 20/ Left Eye 20/

With Correction: Right Eye 20/ Left Eye 20/

Please indicate where applicable:

- \_\_\_\_\_ No Corrective lenses at this time
- \_\_\_\_\_ Corrective lenses\_ Fulltime wear including gym activities
- \_\_\_\_\_ Corrective lenses\_ Fulltime wear excluding gym activities
- \_\_\_\_\_ Corrective lenses\_ For all academic work
- \_\_\_\_\_ Corrective lenses\_ For distance academic work only (blackboard, movies)

Should activities be limited because of eye conditions? \_\_\_\_\_ Yes \_\_\_\_\_ No

Recommendations and remarks \_\_\_\_\_

Re-evaluation of this patient has been recommended in: \_\_\_\_\_ Months \_\_\_\_\_ Year

\_\_\_\_\_  
Physician's Signature & Stamp  
Address & Phone Number