Vision Screening Referral Letter

Date_____

Child's Name _____ Grade_____

Dear Parent:

The vision screening recently performed at school indicates that your child is in need of further evaluation. This does not mean that your child has a vision problem, but it does mean that he or she should be evaluated by an optometrist or ophthalmologist. We urge you to give this your immediate attention.

Please make an appointment with your child's optometrist or ophthalmologist as soon as possible. It is important to know the outcome of the professional examination, so **please return the bottom of the form to the school with the results of the exam.**

If you have any questions, please contact the school nurse.

Sincerely,

Tamra Ching, RN
Castlewood School Nurse
605-793-2497

Heidi Mennenga, PhD, RN
Assistant Professor, SDSU
605-688-6924
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Screening Results:

1st Date screened	□ With correction	□ Without correction	**2nd Date Screened**	□ With correction	□ Without correction
Distance Visual Acuity: R 20/_____ L 20/_____			**Distance Visual Acuity:** R 20/_____ L 20/_____		

Dear Doctor:

Please complete this portion of the form and return to the patient so it may be brought to the school nurse.

I have examined_____ on __/__/__.

I feel the eye problem is:	I expect that on completion of whatever treatment is necessary there will be:
Vision defect: ( ) Not sufficient to require treatment ( ) Muscular ( ) Fully treatable ( ) Myopia ( ) Partially treatable ( ) Hyperopia ( ) Not treatable ( ) Astigmatism ( ) Glasses prescribed ( ) Suppression	( ) No significant visual handicap that may interfere with learning. ( ) Visual handicap that may interfere with learning.

Special recommendations: _____

Signed _____