Appendix B

Suggested Form for Medical Referral/Report

Referral for Eye Examination:

_____

(Student's Name) (DOB) (Sex) (Grade)

To: _____
(Parent's Name)

_____
(Address) (Telephone)

From: _____
(Name of School Nurse) (School Name)

Address: _____

Telephone: _____

Recently we have administered vision screening tests to students in our school. Based on these test results, it would be desirable for your child to have a thorough eye examination. Therefore, it is suggested that you take her or him to an eye specialist (ophthalmologist, optometrist) for further examination or that you follow the recommendations of your family physician.

Date of Test(s): _____

Glasses worn for test: Yes No

Distance Visual Acuity: Right eye _____ Left eye _____

Other Symptoms: _____

_____

Report of Eye Examination

		Distance Vision		Near Vision	
		Without Correction	With Correction	Without Correction	With Correction
A.	Right Eye	_____	_____	_____	_____
	Left Eye	_____	_____	_____	_____

B. Type of Eye Problem: _____

C. Glasses needed: No ☐ Yes ☐
To be worn: Constantly ☐ Classroom ☐ Distance ☐ Close Work ☐

D. Reexamination advised in: _____

E. Eye Muscle Coordination: Adequate ☐
Remarks : _____

F. Ability to change focus quickly and easily: (Example: chalkboard to book)
Adequate ☐ Remarks: _____

G. Ability to maintain focus at reading distance: Adequate ☐
Remarks: _____

H. Color Vision: Normal ☐
Remarks: _____

I. Physical Activity: Restricted ☐
Remarks: _____

J. Other Comments:

_____

_____

Signature of Examiner _____

Date of Examination _____

Please forward this report to school nurse, address above.