SAMPLE

<District/School Name or Letterhead>
Vision Referral Letter

Date________________________

Dear Parent/Guardian:

Recent vision screening test at school indicates that ____________________________ may have some vision difficulty. A comprehensive eye examination is recommended. Please take this form with you at the time of examination.

__________________________________________
(School Nurse)

REASON FOR REFERRAL

Vision Test Results________________________ Screening Tool(s) used*: ___________________________
☐ Blinking ☐ Blurred Vision ☐ Frequent headaches after reading
☐ Squinting ☐ Watering Eyes ☐ Other ___________________________

Remarks__________________________________________
* If an automated screening was used, attach printout from the machine.

EYE EXAMINER’S REPORT TO SCHOOL

Diagnosis: __________________________________________________________________________

☐ No Treatment Indicated
☐ Treatment Recommended
 ☐ Glasses Prescribed
    ☐ To be worn at all times
    ☐ To be worn at all times except during physical education
    ☐ To be worn for far vision activities, e.g., driving, looking at the board
    ☐ To be worn for near vision activities, e.g. computer work, reading, writing Other:
___________________________________________________________________________________

Vision to be expected with correction: R 20/ L 20/

Classroom/School Recommendations:
___________________________________________________________________________________

Recommended Date for Re-examination: ____________________________

We would appreciate any additional information which may be pertinent to this student’s school adjustment.

Date________________________ Name of Eye Examiner (MD, DO, or OD)
Phone/Email________________________ Signature of Eye Examiner

NOTE: Please complete and return to the school nurse. Thank you.