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Phone (570) 853-4921

www.scschools.org



**Elementary School
Health Office**
Ext. 1345 or 1343
Fax: (570) 853-3092

**High School
Health Office**
Ext. 2347
Fax: (570) 853-3918

SCHOOL HEALTH PROGRAM VISION SCREENING REFERRAL

Name _____ Age _____ Sex _____

Address _____ Grade _____ Teacher _____

Dear Parent:

We have completed the vision screening service provided as part of the School Health Program. Results of your child's vision test indicate the need for a complete eye examination. The findings of the school vision screening test are recorded below:

FINDINGS: SCHOOL SCREENING TEST

Results: _____ Date: _____

Visual acuity: Right Left

Far: _____

Glasses/Contacts _____

Near: _____

Testing Method (s): Titmus Vision Tester _____

Other: _____

Comments: _____

Since uncorrected vision disorders can affect learning potential, it is important to have your child's eye specialist complete the form on the back of this letter and return it to the school when completed.

Thank you for your cooperation. If you have any questions or need assistance, please contact one of the offices listed above.

Sincerely,

Health Office

REPORT OF EYE EXAMINATION

Name: _____

Date: _____

Visual Acuity (Far):
Right Left

Acuity (Near):
Right Left

Without correction: _____ _____ _____ _____

With correction: _____ _____ _____ _____

Diagnosis or explanation of eye condition: _____

Plan of treatment:

Glasses prescribed Yes _____ No _____

Worn constantly _____ Distance work only _____

Recommendations for school: _____

When should this child be re-examined? _____

(Print name of eye care specialist)

(Signature of eye care specialist)

(Office telephone number)