

BETHEL PARK SCHOOL DISTRICT  
VISION REFERRAL

Name \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_

Dear Parent/Guardian:

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

**FINDINGS: SCHOOL VISION SCREENING TESTS**

Date \_\_\_\_\_

- |  |                                   |                             |
|--|-----------------------------------|-----------------------------|
| 1. Visual Acuity:                          | <b>FAR</b>                        | <b>NEAR</b>                 |
|  | Right/Left                        | Right/Left                  |
| With glasses:                              | ___ ___ Passed___ Failed___       | ___ ___ Passed___ Failed___ |
| Without glasses:                           | ___ ___ Passed___ Failed___       | ___ ___ Passed___ Failed___ |
| 2. Convex Lens (excessive farsightedness): | Passed___ Failed___ Not tested___ |                             |
| 3. Stereo/Depth Perception:                | Passed___ Failed___ Not tested___ |                             |

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Since uncorrected vision disorders can affect learning potential, it is important to have your child's Eye Care Specialist complete the form on the back of the letter and return it to the Bethel Park High School Health Office.

Thank you for your cooperation. If you have any questions or I can be of assistance, please contact me.

Sincerely,

*The School Nurse*

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EYE SPECIALIST REPORT

Student's Name \_\_\_\_\_ Date \_\_\_\_\_

Visual Acuity:	<u>FAR</u>	<u>NEAR</u>
	Right/Left	Right/Left
Without correction:	____ _	____ _
With correction:	____ _	____ _

Diagnosis or explanation of eye condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Plan of Treatment:

Glasses Prescribed	Yes____	No____
Constant Wear	Yes____	No____
Near Work Only	Yes____	No____
Distance Work Only	Yes____	No____
Contact(s) Prescribed	Yes____	No____

Recommendation for school:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Return visit: \_\_\_\_\_

Please return report to:  
**Your child's School Nurse**

\_\_\_\_\_  
Print Name of Eye Care Specialist

\_\_\_\_\_  
Signature of Eye Care Specialist

\_\_\_\_\_  
Telephone

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