Fresno County
Superintendent of Schools

Health Services
Alma McKenry, Senior Director

Vision Referral

Child's Name: _____

Date of Birth: _____ Grade: _____ Date: _____

Dear Parent:
The nursing assessment has indicated that the above named child should have a complete eye examination.
It is important that (1) you take this form with you to the doctor; and (2) the completed form be returned back to the school.

Note to Examiner:
The parents' attention has been directed toward an eye evaluation because _____

_____

_____

For additional information, please call *(telephone number)* _____

on ☐M ☐T ☐W ☐TH ☐F *(nurse available)* between the hours of _____ and _____.

SCHOOL STAMP

_____
School Administrator

_____
School Nurse

Report of Eye Exam

Diagnosis: _____

Visual Acuity Without Glasses: R 20/_____ L 20/ _____

Visual Acuity With Glasses: R 20/_____ L 20/ _____

If unable to measure acuity with the Snellen Chart, please indicate the student's ability with the maximum correction.

	Right Eye	Left Eye		Right Eye	Left Eye
Totally Blind	_____	_____	Detects Hand Movement	_____	_____
Restricted Visual Field	_____	_____	Object Perception	_____	_____
Counts Fingers	_____	_____	Light Perception	_____	_____

Glasses: ❒ Yes ❒ No When _____

Recommendations: _____

_____

Return Appointment: _____

Return to Another Health Advisor: _____

_____ _____ _____
Examiner *Date* *Telephone Number*

Thank you for returning the completed form to school (via parents or mail). This information is helpful in planning the student's education.