



WINTON SCHOOL DISTRICT VISION REFERRAL

School Site: _____

Phone: _____

Student Name: _____

Date: _____

Dear Parents or Guardians,

As a result of recent vision screening program at school, we believe that your child should have a complete eye examination. We urge you to give this your prompt attention. Please take this form to your EYE doctor and ask him/her to complete it and return it to the school Health Aide. If you desire additional information, the Health Aide will be glad to assist you.

Diane Gannon, District Nurse (209) 357-6585 Completed by: _____

NOTE TO EXAMINER:

We have directed the parent's attention to the need for a complete eye examination. Our results for _____ were as follows:

(Student's Name)

Performance on Snellen test: Right 20/ _____ Left 20/ _____ Both 20/ _____

Signs and symptoms: _____

I would appreciate a report from you with recommendations. Thank you for your assistance in helping the educational process of this student.

REPORT OF EXAMINER TO THE SCHOOL HEALTH AIDE

Without lenses

With Lenses

_____ Not prescribed

Right 20/ _____

Right 20/ _____

_____ Prescribed

Left 20/ _____

Left 20/ _____

_____ To be worn at all times

Both 20/ _____

Both 20/ _____

_____ Wear for close work

Diagnosis: _____

_____ Wear for distance only

_____ Preferential seating

Other Recommendations: _____

Signature _____

Optometrist Name _____

(Printed)

Date care given: _____

Address: _____