HS0066 Rev. 3/20

VISION REFERRAL LETTER

Health Services Department Lincoln Public Schools

	Date:		
To the Parent/Guardian of:	Student ID #:		
Failed Vision Screen			
A vision screening has been completed as p results, it is recommended to follow up with	eart of the School Health Program. Based on your child's an eye care specialist.		
Screening Date: U	Vith Glasses/Contacts □ Without Glasses/Contacts		
Right Eye: Left Eye: _			
☐ Failed screening with Vision Spot Screene	r		
☐ Two-line difference (or greater) between rig	ght and left eye		
Expected Screening Results:			
DISTANCE VISION AT 10 FEET	NEAR VISION (BINOCULAR) AT 16 INCHES		
Preschool: 20/50 or better Kindergarten: 20/40 or better All Other Grades: 20/30 or better	Preschool: 20/50 or better Kindergarten: 20/40 or better All Other Grades: 20/30 or better		
Vision Spot Screener (all ages): Pa	assing result		
Additional Comments:			
Vision disorders can affect learning. Please hof this form and return it to school.	nave your child's eye care specialist complete the back		
If you do not have access to insurance cove health office for assistance.	rage or Medicaid for eye exams, please contact the		
Thank you for your partnership.			
School Nurse:	Phone:		

EYE EXAMINATION REPORT

Health Services Department Lincoln Public Schools

Student DOB: Visual Acuity: 20 feet: Right/ Left/ with/without correction 16 inches: Right/_ Left/_ with/without correction Diagnosis or explanation of eye condition: Plan of Treatment: Glasses Prescribed	Student Name:			Date:	
20 feet: Right/ Left/_ with/without correction 16 inches: Right/_ Left/ with/without 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 Recommendations for school: Return visit if indicated: Signature of eye care specialist: Please print: Name of eye care specialist:	Student DOB:		-		
16 inches: Right/ Left/ with/without correction Diagnosis or explanation of eye condition: Plan of Treatment: Glasses Prescribed	Visual Acuity:				
Plan of Treatment: Glasses Prescribed	20 feet: Right/	Left _	/	with/without correction	
Plan of Treatment: Glasses Prescribed	16 inches: Right/	Left _	/	with/without correction	
Glasses Prescribed	Diagnosis or explanation of eye of	condition:			
Glasses Prescribed					
Glasses Prescribed					
Glasses Prescribed					
Constant Wear	Plan of Treatment:				
Near Work Only Distance Work Only Yes No Contact(s) Prescribed Yes No Recommendations for school: Return visit if indicated: Signature of eye care specialist: Please print: Name of eye care specialist:					
Distance Work Only					
Contact(s) Prescribed	•				
Return visit if indicated: Signature of eye care specialist: Please print: Name of eye care specialist:	•				
Signature of eye care specialist: Please print: Name of eye care specialist:	Recommendations for school:				
Signature of eye care specialist: Please print: Name of eye care specialist:					
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Signature of eye care specialist: Please print: Name of eye care specialist:	Return visit if indicated:				
Please print: Name of eye care specialist:					
Name of eye care specialist:	Signature of eye care specialist:				
Adduses and phane numbers					
Address and phone number:	Address and phone number:				_

(Return report to School Nurse)