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 part of the School Health Program. Based on your child's results, it is recommended to follow up with an eye care specialist.

Screening Date: _____ ☐ With Glasses/Contacts ☐ Without Glasses/Contacts

Right Eye: _____ Left Eye: _____

☐ Failed screening with Vision Spot Screener

☐ Two-line difference (or greater) between right 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): Passing result	

Additional Comments:

Vision disorders can affect learning. Please have your child's eye care specialist complete the back of this form and return it to school.

If you do not have access to insurance coverage or Medicaid for eye exams, please contact the health office for assistance.

Thank you for your partnership.

School Nurse: _____ Phone: _____

EYE EXAMINATION REPORT

Health Services Department
Lincoln Public Schools

Student Name: _____ Date: _____

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	☐ 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: _____

Address and phone number: _____

_____

(Return report to School Nurse)