MONROE SCHOOL DISTRICT

# Referral for Eye Examination

Student:_____ Birth Date:_____ School:_____

Dear Parent/Guardian:
A recent vision screening at school indicates your child may have a vision concern. We recommend your child have a professional eye examination. Please take this form with you at the time of the examination and return the completed form to the school. If you have questions please call the health room at _____.

School Nurse:_____Date:_____

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**School Report to Eye Examiner:**

We are referring this student to you for the following reason: ☐ Screened w/ corrective lenses

Failed the Vision Screening: **FAR**:☐ Right _____ ☐ Left_____ ☐**NEAR** _____

Comments for visual concern: _____

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**Eye Examiner Report to School:**

1. Visual acuity: (a) Without correction R 20/_____ L 20/_____
   (b) With correction R 20/_____ L 20/_____
   (c) Near vision acuity R 20/_____ L 20/_____
2. Glasses: ☐ Prescribed ☐ Not prescribed
   ☐ To be worn at all times
   ☐ To be worn for close work only
   ☐ To be worn for distance only
   ☐ To be used in games and sports
3. Diagnosis: _____
4. When should the student return for a re-examination: _____
5. Comments: _____

   _____

Eye Examiner: _____ Date: _____

Clinic Address: _____

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***Please return completed form to school office***

***For school office use only**: Updated information entered into Skyward Date: _____ By_____*