[illegible] UNION FREE SCHOOL DISTRICT

SCHOOL HEALTH PROGRAM

NOTICE REGARDING ANNUAL VISION SCREENING TEST

Pupil's Name _____ Date _____

School _____ Grade _____

TO PARENT OR GUARDIAN:

[illegible] that your child may have some eye difficulty. A complete eye examination is recommended to determine the need for professional care. This [illegible] should be returned to the nurse.

TO THE EXAMINER:

Your diagnosis and recommendations will be appreciated and will assist us in planning this child's School program.

SCHOOL OBSERVATIONS:

TEST RESULTS: Visual Acuity

TEST USED: New York Vision Tester

Distance: R: 20/_____; L: 20/_____

Near: _____

_____

School Nurse

EXAMINER'S DIAGNOSIS AND RECOMMENDATIONS:

Date of examination _____ **200**_____

1. **Diagnosis: R-** _____

   L- _____

[illegible] **R20/** [illegible] **h. With R20/**

Acuity Correction L20/_____ **Correction L20/**_____

3. **Are glasses to be worn? Yes**_____ **No**_____

4. **If yes indicate extent of use** _____

5. **Interscholastic sports: if student's uncorrected vision is 20/200 or worse in either eye is student able to participate in contact sports? Yes**_____, **No**_____.

[illegible] **SIGNATURE** _____

EXAMINER'S STAMP: