BEEVILLE
INDEPENDENT SCHOOL DISTRICT

Vision Referral Letter

Date_____

Dear Parent/Guardian:

Recent vision screening test at school indicates that _____ may have some
(student name and grade)
vision difficulty. A comprehensive eye examination by a vision specialist is recommended. Please take this form with you at the time of examination.

_____ _____
(School Nurse) (School Contact information)

REASON FOR REFERRAL

Vision Test Results: Pass Fail Screening Tool(s) used: Wall Chart Photoscreener*
Acuity Right Eye _____ Acuity Left Eye _____

☐ Blinking ☐ Blurred Vision ☐ Frequent headaches after reading

☐ Squinting ☐ Watering Eyes ☐ Other _____

Remarks_____

* If an automated screening was used, attach printout from the machine.

EYE EXAMINER'S REPORT TO SCHOOL

Diagnosis: _____

☐ No Treatment Indicated

☐ Treatment Recommended

- ☐ Glasses Prescribed
  - ☐ To be worn at all times
  - ☐ To be worn at all times except during physical education
  - ☐ To be worn for far vision activities, e.g., driving, looking at the board
- ☐ To be worn for near vision activities, e.g. computer work, reading, writing Other:
  _____

Vision to be expected with correction: R 20/ L 20/

Classroom/School Recommendations:

_____

Recommended Date for Re-examination: _____

We would appreciate any additional information which may be pertinent to this student's school adjustment.

Date_____ _____
Name of Eye Examiner (MD, DO, or OD)

Phone/Email_____ _____
Signature of Eye Examiner

NOTE: Please complete and return to the school. Thank you.