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**Elementary School
Health Office**
Ext. 1345 or 1343
Fax: (570) 853-3092



**High School
Health Office**
Ext. 2347
Fax: (570) 853-3918

SCHOOL HEALTH PROGRAM VISION SCREENING REFERRAL

Name _____ Age _____ Sex _____

Address _____ Grade _____ Teacher _____

Dear Parent:

We have completed the vision screening service provided as part of the school health program. Results of your child's vision test indicate the need for a complete eye examination. The findings of the school vision screening test are recorded below:

FINDINGS: SCHOOL SCREENING TEST

Results: _____ Date: _____

Visual acuity: (Far) Right Left

With glasses: _____ _____

Without glasses: _____ _____

Testing Method (s): Snellen _____

Titmus Vision Tester _____

Comments: _____

Since uncorrected vision disorders can affect learning potential, it is important to have your child's eye specialist complete the form on the back of this letter and return it to the school when completed.

Thank you for your cooperation. If you have any questions or I can be of assistance, please contact me.

Elementary Health Office

