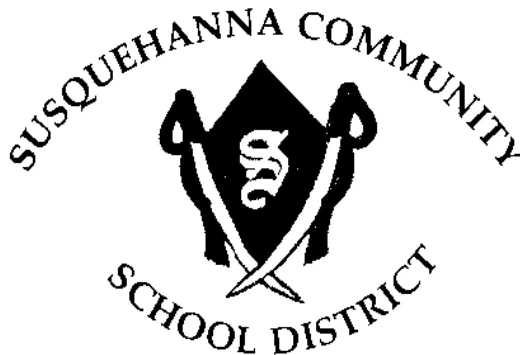
3192 Turnpike St., Susquehanna, PA 18847 Phone (570) 853-4921 www.scschools.org




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

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

*Vision Screening Examination Request*

Dear Parent/Guardian of ________________________________________:

We have completed the annual vision screening on your child, and are requesting a report from your private eye care specialist. This report can be completed on the reverse of this form and returned to the Health Office, or faxed to the number listed above.

Thank you for your cooperation and prompt attention. If you have any questions, please contact our office during regular school hours. If you have an upcoming exam scheduled, please let us know of the date so we know when to expect the report.

Results of School Exam

(date: ______________)

| Acuity Far: | Right | Left | Acuity Near: | Right | Left |
|---|---|---|---|---|---|
| | _____ | _____ | | _____ | _____ |

Testing Method: Titmus Vision Tester / SureSight

Comments: ________________________________________________________________

________________________________________________________________

________________________________________________________________

Sincerely,

Elementary Health Office Staff

(over)

## REPORT OF EYE EXAMINATION

Name: ______________________________

Date: _______________________________

| | Visual Acuity (Far): | | Acuity (Near): | |
|---|---|---|---|---|
| | Right | Left | Right | Left |
| Without correction: | __________ | _________ | _________ | _________ |
| With correction: | __________ | _________ | _________ | _________ |

Diagnosis or explanation of eye condition: ______________________________________________

_______________________________________________________________________________________

Plan of treatment:

Glasses prescribed Yes__________ No__________

Worn constantly___________________ Distance work only______________________

Recommendations for school: ________________________________________________________

_______________________________________________________________________________________

When should this child be re-examined? ______________________________________________

_______________________________________________________________________________________

_________________________________
(Print name of eye care specialist)

_________________________________
(Signature of eye care specialist)

_________________________________
(Office telephone number)