

Clarksville Montgomery County School System HEALTH SERVICES MASS VISION SCREENING RECORDING FORM

School: _____ Grade/Teacher: _____ Date: _____

NOTE: Grades K-3 should be rescreened/referred at 20/40 or worse in either eye. Grades 4-12 should be rescreened/referred at 20/30 or worse in either eye.

NAME	GLASSES OR CONTACT LENSES "X" if yes	SCREENED WITH GLASSES OR CONTACT LENSES "X" if yes	FAR VISUAL ACUITY		RESCREEN FAR VISION		NEAR VISUAL ACUITY		RESCREEN NEAR VISION		REFER "X" if yes
			R	L	R	L	R	L	R	L	
Last Name, First Name	"X" if yes	"X" if yes	R	L	R	L	R	L	R	L	"X" if yes

Forward a copy of completed form to the classroom teacher.