



Clarksville Montgomery County School System
HEALTH SERVICES
VISION REFERRAL

Date \_\_\_\_\_

Name \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Dear Parent:

The results of the school vision screening showed that your child may have some eye difficulty. A follow up by your physician is indicated. The results of this examination will assist school personnel in making all necessary modifications to your child's educational program.

Without Correction:

Distance Acuity: Right Eye 20/ Left Eye 20/

Near Acuity: Right Eye 20/ Left Eye 20/

Plus Lens (+2.25): Results \_\_\_\_\_

\_\_\_\_\_  
School Nurse

This form should be completed by the examining physician and returned to the school nurse.

Date of Examination \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Visual Acuity:

Without Correction: Right Eye 20/ Left Eye 20/

With Correction: Right Eye 20/ Left Eye 20/

Please indicate where applicable:

- \_\_\_\_\_ No Corrective lenses at this time
\_\_\_\_\_ Corrective lenses\_ Fulltime wear including gym activities
\_\_\_\_\_ Corrective lenses\_ Fulltime wear excluding gym activities
\_\_\_\_\_ Corrective lenses\_ For all academic work
\_\_\_\_\_ Corrective lenses\_ For distance academic work only (blackboard, movies)

Should activities be limited because of eye conditions? \_\_\_\_ Yes \_\_\_\_ No

Recommendations and remarks \_\_\_\_\_

Re-evaluation of this patient has been recommended in: \_\_\_\_\_ Months \_\_\_\_\_ Year

\_\_\_\_\_  
Print or Type Name of Licensed Ophthalmologist or Optometrist

\_\_\_\_\_  
Signature of Licensed Ophthalmologist or Optometrist

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Fax Number