



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