Solvay Schools ~ Student Health Services

Notice Regarding Vision Screening

Dear Parent:

Your child received a vision screening at school on at by School Nurse .

The following results were obtained:

Test	Without Correction	With Glasses/Contacts
Distance Acuity	20/	20/
Near Acuity	20/	20/

Other Observations:

It is recommended that your child's eyes be examined by an eye care specialist. Please ask the eye specialist to complete the section below.

REPORT OF EYE CARE SPECIALIST:

Date of Examination: _____Date of Next Appointment _____

Diagnosis: _____

Lens Requirements ☐ Correction required ☐ Correction not required
☐ Glasses ☐ Contact lenses

Corrected Visual Acuity: Right: 20/_____ Left: 20/_____

Frequency of Classroom Use: ☐ Wear at all times ☐ Wear for distance only
☐ Wear for reading only ☐ Wear during Phys. Ed./Sports
☐ Safety goggles required for Phys. Ed. /Sports

Other Recommendations: _____

Signature of Eye Care Provider: _____

Address: _____

Phone: _____

PARENT: PLEASE RETURN THIS FORM TO THE SCHOOL NURSE AFTER EYE EXAM.