NOTICE TO PARENTS OF NEED FOR AN EYE AND VISION EXAMINATION

Date: _____ School: _____

Student: _____ Grade: _____ Teacher: _____

Your child passed the eye and vision screening test: ☐ Yes ☐ No

REASON FOR NOT PASSING

Blurred vision at distance ☐
Blurred vision at near ☐
Plus (+) Lens Test ☐
Eye Muscle Problem ☐
Eye Health ☐
Other _____ ☐

Dear Parent:

Your child's performance in school is dependent on his/her ability to see. Eighty (80%) of what we learn comes through our eyes. If your child's eyes need help, please don't deprive him/her of the opportunity to do as well as other children.

State law states: **A child who does not pass the eye and vision screening tests shall be required to have a comprehensive eye and vision examination conducted by an optometrist or ophthalmologist within sixty (60) days of receipt of the vision screening report. Arkansas Code Annotated § 6-18-1502**

Thank you for your cooperation.

Parent authorization to release medical eye information (Signature) _____

REPORT OF DOCTOR'S EVALUATION

Visual Acuity	@ 20 feet	@ near		@20 feet	@ near
Without Rx	Right 20/____	20/____	**With Rx**	Right 20/____	20/____
	Left 20/____	20/____		Left 20/____	20/____

Eye Muscles A - Normal B - Subnormal
Accommodation: _____ Convergence: _____ Binocularity: _____ Eye movement: _____

Eye/Vision Diagnosis

Right	Hyperopia____	Myopia____	Astigmatism____	Amblyopia____	Muscle Problem____
Left	Hyperopia____	Myopia____	Astigmatism____	Amblyopia ____	Muscle Problem____

Internal and External Eye Health _____
Glasses Prescribed Yes No **To be worn:** Full time Distance only Reading only
Other problems (comments or instructions) _____
Date of Examination: ____/____/____ Date of Re-examination: ____/____/____

Examiner's Name _____ Signature _____

Address _____ Phone _____ Date: _____

_____

Please fax to: _____ Fax Number: _____