

Ohio Department of Health Eye Specialist Report

School Screening Information

Child's Name	Date of Referral								
School	Grade								
Reason for referral (test failed or type of symptom)									
<table style="width: 100%;"> <tr> <td style="width: 25%;">School Screening visual acuity</td> <td style="width: 25%;">without glasses</td> <td style="width: 25%;">with glasses</td> <td style="width: 25%;"></td> </tr> <tr> <td></td> <td>R _____ L _____</td> <td>R _____ L _____</td> <td></td> </tr> </table>		School Screening visual acuity	without glasses	with glasses			R _____ L _____	R _____ L _____	
School Screening visual acuity	without glasses	with glasses							
	R _____ L _____	R _____ L _____							

Eye Specialist

Distance Visual Acuity	without correction	with current prescription	with new prescription
	R _____ L _____	R _____ L _____	R _____ L _____
Summary of vision problems and diagnosis			
<hr/> <hr/> <hr/>			
Recommendations			
Additional instructions for teacher			
<hr/> <hr/> <hr/>			
Is further treatment necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No		I wish to see the child again. <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, specify		If yes, when?	

Please return form to

From

	Eye Specialist		
	Address		
	City	State	ZIP
	Date		

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