

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%; border: none;"> <tr> <td style="width: 50%; border: none;"> School Screening visual acuity without glasses R _____ L _____ </td> <td style="width: 50%; border: none;"> with glasses R _____ L _____ </td> </tr> </table>		School Screening visual acuity without glasses R _____ L _____	with glasses R _____ L _____
School Screening visual acuity without glasses R _____ L _____	with glasses 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.
If yes, specify			<input type="checkbox"/> Yes <input type="checkbox"/> No
			If yes, when?

Please return form to

From

	Eye Specialist		
	Address		
	City	State	ZIP
	Date		

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