Washington School District

School Nurse Department
201 Allison Avenue
Washington, PA 15301
Phone 724-223-5087 Fax 724-223-5045

Vision Screening Referral

Name_____________________________________ Age_____ Sex_______
Grade______ Teacher____

Date:_____________

Dear Parent/Guardian:
____________________________ **DID NOT PASS** the vision screening test given at Washington Jr/Sr High School on ______________. This service is provided as part of the School Health Program. These results indicate the need for an eye examination by an Eye Care Specialist.

Since uncorrected vision disorders can affect learning potential, it is important to have your child's Eye Care Specialist complete the back of this letter and return it to the school. Thank you for your cooperation. If you have any questions, please do not hesitate to call me at (724) 223-5087.

Sincerely,

Ashley Brand, RN, BSN, CSN
Certified School Nurse
Washington Jr/Sr High School

Washington School District

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Washington, PA 15301
Phone 724-223-5087 Fax 724-223-5045

Eye Specialist Report

Student's Name ________________________________ Date: ____________

Visual Acuity:

	FAR Right/Left		NEAR Right/Left	
Without Correction	____	____	____	____
With Correction	____	____	____	____

Diagnosis or explanation of eye condition:
____
____
____

Plan of Treatment:

Glasses Prescribed	Yes ___	No ___
Constant Wear	Yes ___	No ___
Near Work Only	Yes ___	No ___
Distance Work Only	Yes ___	No ___
Contacts Prescribed	Yes ___	No ___

Recommendation for School:
____
____
____

Return Visit: _______________________
(Return Report to School)

____
Print Name of Eye Care Specialist

____
Signature of Eye Care Specialist

____
Telephone